Coordinated Responses to Violence against Women

A Documentation of Interventions
Supported by the
UNFPA India Country Office

UNFPA
United Nations Population Fund - India

10775

Community Health Cell
Library and Information Centre
359, "Srinivasa Nilaya"
Jakkasandra 1st Main,
1st Block, Koramangala,
BANGALORE - 560 034.
Ph : 2553 15 18 / 2552 5372
e-mail : chc@sochara.org

Coordinated Responses to

Violence against Women

A Documentation of Interventions

April, 2007

United Nations Population Fund - India

WH-170
10775 P07

Abbreviations and Acronyms

ANM	Auxiliary Nurse Midwife
AWW	Anganwadi Worker (an anganwadi is a government-supported day-care centre for children below 6 years)
BMC	Brihanmumbai Municipal Corporation
BMF	Bharatiya Mahila Federation
CP6	Sixth Country Programme
CrPC	Criminal Procedure Code
DCP	Deputy Commissioner of Police
FCC	Family Counselling Centre
GBV	Gender-based Violence
ICPD	International conference on Population and Development, Cairo, 1994
IPDP	Integrated Population and Development Programme
MIS	Management Information Systems
NCW	National Commission for Women
NHG	Neighbourhood Group
NHRC	National Human Rights Commission
PMC	Pune Municipal Corporation
PMM	Pragatisheel Mahila Manch
PMO	Principal Medical Officer
RCH	Reproductive and Child Health
RCH2	Reproductive and Child Health programme, Phase 2
RCHO	Reproductive and Child Health Officer
RCV	Residential Community Volunteer
TISS	Tata Institute of Social Sciences, Mumbai
TMC	Thane Municipal Corporation
VAW	Violence against Women
VCTC	Voluntary Counselling and Testing Centre for HIV/AIDS

Contents

Executive Summary

The UNFPA India Country Office, through the Integrated Population and Development Programme (IPDP), has been working closely with the Government of India at the national and state levels to bring about a strong focus on gender in their Reproductive and Child Health programme (RCH). Within the overall rubric of addressing gender-based vulnerabilities that impinge on women's health, UNFPA has been working closely with the Government of India as well as with the state governments to strengthen health-sector responses to violence against women (VAW). UNFPA has done this by collaborating actively with the Department of Health and Family Welfare and the National Commission for Women (NCW), a statutory body set up by the Government of India to engage actively with the government in promoting policies and programmes for women, with a specific focus on VAW.

UNFPA has been mobilizing support in the health sector for adequate attention to and inclusion of issues related to VAW through policy dialogues at every level, large-scale and sustained sensitization of health-care providers to VAW, production and dissemination of relevant material on VAW, and the development of practical tool kits for building the capacities of health-care providers in addressing VAW within their settings. UNFPA has also been supporting pilot interventions on VAW aimed at strengthening systemic responses, and demonstrating the viability of developing health-sector responses to VAW. The report highlights the functioning of some of these interventions and culls out the key lessons learned in implementing these projects, with implications for scaling up.

The UNFPA India Country Office is supporting the following interventions aimed at addressing VAW and facilitating preventive processes in five states of India—Madhya Pradesh, Orissa, Rajasthan, Maharashtra, and Kerala. The specific interventions being implemented in each state include:

- Hospital-based Family Counselling Centres (FCCs) in select sites in Rajasthan and Maharashtra
- Police help desks located in police stations in Orissa
- Counselling centres located within community settings in Maharashtra
- FCCs located within police stations in Madhya Pradesh

The report specifically examines the functioning of the following interventions:

1. Hospital-based FCCs located in Alwar and Karauli districts of Rajasthan and the Thane Municipal Corporation (TMC), Maharashtra
2. Counselling centres located within community settings in Pune city, Maharashtra as well as those being run in Bhiwandi and Kalyan, two suburbs of Mumbai, Maharashtra.

At all these sites, with the exception of Pune, the interventions have been carried out through NGO partners and have been on the ground for one or two years. The FCC run by the TMC is the oldest of these interventions; it has been operational for five years.

The report is divided into six sections.

Section I provides a broad conceptual overview of the health dimensions of VAW.

Sections II and III highlight the work of UNFPA India's country programmes in the area of VAW.

Section IV examines hospital-based interventions on VAW supported by UNFPA and state governments.

Section V looks at interventions that are located in the community and that seek to develop broader community involvement in curbing VAW.

Section VI describes the key lessons learned in implementing the interventions discussed in the report.

Section VII examines some policy and programme recommendations aimed at strengthening the interventions.

Key insights and lessons emerging from the documentation of the UNFPA India Country Programme-supported interventions on VAW

The experiences in implementing these interventions have highlighted the role of several factors—environmental and otherwise—in determining their approach, outreach, and ultimately their effectiveness. Key among these are:

a) **The broader policy and programme environment related to women and health** prevalent in the state, which reiterates the government's commitment to the issue and thereby places the issue on the agenda of government officials and front-line workers. The states of Rajasthan and Maharashtra are examples.

b) **The orientation and approach of the given NGO** to development practice in general, and particularly to issues of gender and women's rights. This is a very important factor as it determines the approach adopted by the agency in addressing cases of VAW, the process followed in empowering women, and the positions adopted by the implementer in dealing with the system. For instance, Aarohi, the counselling centre located in the Chhatrapati Shivaji Maharaj Hospital, Kalwa, TMC, adopts a woman-centric strategy for counselling, aimed at building the woman's notion of the self and increasing her ability to make decisions about her situation.

c) **The credibility, track record, and institutional networks of the implementing partner** determine the influence and negotiating power it enjoys in dealing with the medical system, the police, other service providers, etc. Indeed, this has been one of the major factors responsible for the growing success of the interventions, as all the partners implementing the interventions enjoy enormous credibility with the government systems, and also have a strong community presence.

d) **The skill levels and perspective of the counsellors** providing support services to women facing violence is a critical factor as it determines the processes adopted in counselling and the nature of support provided to women. The training and skills of the counsellors at Aarohi, for example, have enabled them to provide a strong therapeutic angle to their intervention, which may not be necessarily evident in other centres.

e) **The level of gender sensitivity, understanding, and openness** present within formal government and leadership structures at every level, but particularly at the field level, has played an important role in determining the level of cooperation from the government systems. For example, the support of hospital superintendents in some sites has ensured that two beds are always reserved as emergency shelter for women trapped in abusive families. Elsewhere, the FCCs, for example those in Rajasthan, have had to struggle with the challenge of sensitizing indifferent government officials who are directly connected with the intervention. This compromises the mandate of the intervention.

- One of the most significant learnings gleaned from the functioning of the hospital-based counselling centres has been the importance and advantage of locating the FCC within the hospital premises. It provides a readily available referral mechanism for doctors. It also simplifies issues of access, time, and ready availability of services to women seeking its services. Most importantly, availing the services of the FCC is non-stigmatizing, and the woman does not have to make a special effort to visit the centre since it is located within the hospital. By becoming a part of the hospital, at the very least in a physical sense, the FCC also projects the importance of this service as an addendum to the treatment of physical illnesses.

- The hospital-based counselling centres are also performing a very significant function by mediating on behalf of the client with the health system for medical services and facilities. This has been an unintended result of the intervention. The importance of setting up and supporting violence-intervention services located within a health-care setting is strongly validated through the interventions reviewed in this report.

It is important to note that these factors are neither static nor uniform across all districts. They do not operate in a singular or linear fashion. Very often, it is a combination of these factors that determines how effectively the intervention is functioning. At the same time, the priority accorded by the state government to issues such as violence changes in response to conflicting demands posed by poor infrastructure, lack of doctors in general and female doctors in particular, misuse of power, and low levels of motivation.

Several signs of change are becoming evident as a result of the interventions. However, the signs of change need to be read with three riders to them:

a) Owing to the relatively short period of time for which the interventions have been on the ground, what is evident right now in terms of change are pointers to variations in perceptions and levels of sensitivity of various stakeholders to the issue of VAW.

b) Owing to paucity of data, there is little empirical evidence with which to substantiate the change being reported by the implementers. The signs of change presented in the report are qualitative and anecdotal.

c) The Management Information System (MIS) is not geared currently towards empirically measuring and demonstrating the 'value added' by the interventions in terms of health outcomes, either in the short run or in the long run.

Some of the emerging signs of change that are significant are:

- Doctors and other paramedical staff are much more sensitive to the issues of gender and VAW.

- The value added by hospital-based FCCs is the creation of a proper system through which health service providers can deal with cases of VAW by means of referrals.

- The existence of community-level and hospital-based counselling centres has led to better detection of cases of VAW.

- Owing to the success of the interventions, the TMC has taken over the FCC in Thane, Maharashtra, and three more community counselling centres have been established by the PMC.

- The implementers have reported a definite increase in the level of cooperation from the police, the community, and medical personnel because of the commitment of and rigorous casework undertaken by the counsellors.

Introduction

Violence against women and its implications for women's health

Violence against women is one of the most frequently studied subjects, but it continues to be one of the worst forms of vulnerability faced by women across the world. It acts as a formidable barrier to women's development, with serious negative consequences for their physical and mental health. A multi-site study in India found that women who reported experiencing domestic violence were also more likely to report overall poor or very poor general health.[1] Similar results have emerged from the recently concluded WHO multi-country study on domestic violence.[2] In a majority of settings covered by this study, women reporting abuse by their husbands or partners also reported difficulty in walking and carrying out daily activities and suffering from pain, memory loss, dizziness, and vaginal discharge. All women reporting intimate partner violence also reported significantly higher emotional distress than non-abused women.

Analyses of hospital records conducted as part of various research studies in India have shown that hospitals are an important external contact point for women facing violence. A. S. Daga, Shireen Jejeebhoy, and Shantha Rajgopal in a study of records from the casualty ward of J. J. Hospital, Thane (1999)[3] found that as many as 23 per cent, or almost one in four, women patients could be classified as victims of definite cases of domestic violence. They were found to have either suffered an assault by a family member or a 'known person', or, in a minority of cases, they attributed the burns they suffered to their husband or other family members. Another 44 per cent of all women appeared to be possible victims of violence. In their study of records of medico-legal cases of women, Jaswal et al. found that close to 53 per cent of cases were related to domestic violence.[4] In another study by Ganatra, Koyaji, and Rao, 15.7 per cent of pregnancy-related deaths in the community and 12.9 per cent in the hospital were associated with domestic violence.[5] A one-year study of suicides in Delhi found that 56 per cent of suicide cases were women and that marital discord was the most commonly reported cause.

Some significant dimensions of violence and women's health are:[6]

- Physical violence and sexual abuse can put women at risk of infection and unwanted pregnancies *directly*. In a large-scale survey of men in Uttar Pradesh[7], men who admitted to having forced their wives to have sex were 2.6 times more likely than other men to have caused an unintended pregnancy.

[1] A summary report of a Multi-site Household Survey, INCLEN–ICRW, 2000.
[2] WHO Multi-country study on women's health and domestic violence against women: Initial results on prevalence, health outcomes and women's responses, Summary report, 2006.
[3] A. S. Daga, Shireen Jejeebhoy, and Shantha Rajgopal. Domestic Violence: What Hospital Records Tell Us. Lawyers' Collective. 16(3), May 1999, pp. 14–16.
[4] Surinder Jaswal et al Health records and domestic violence in Thane district, 2000.
[5] B. R. Ganatra, K. J. Koyaji, and V. N. Rao. Community cum hospital-based case control study on maternal mortality: A final report. Pune, India, KEM Hospital Research Centre, 1996.
[6] Compiled from various research studies cited in Population Reports, vol. 27, no. 4, December 1999
Quoted in L. Heise, M. Ellsberg, and M. Gottemoeller, 'Ending Violence Against Women', Population Report, Series L, no. 11, Baltimore: Johns [5]
[7] Hopkins University School of Public Health, Population Information Programme, December 1999

- A history of child sexual abuse can also lead to unwanted pregnancies and STIs *indirectly* by increasing sexual risk taking in adolescence and adulthood. Studies in Barbados, New Zealand, Nicaragua, and the United States confirm that, on average, sexual abuse victims start having voluntary sex significantly earlier than non-victims.

- Violence compromises HIV protection as women may fear discussing condom use and safe sex with their partners. In a study of women in Mumbai by George and Jaswal (1995), women reported that bringing up the subject of condom use—with implications that one partner or the other has been unfaithful—risks a violent response.

- Violence can lead to high-risk pregnancies, low birth weight (a leading cause of infant deaths in developing countries), and even maternal deaths. In India, verbal autopsies from maternal deaths from over 400 villages and seven hospitals in three districts of Maharashtra revealed that 16 per cent of all deaths during pregnancy were due to domestic violence (Ganatra et al. 1996). Thus, the health implications of VAW are many, affecting not only the woman herself but also her children and elders in the family. The intergenerational costs of violence undermine human productivity, self-determination, and overall societal health. The recognition of violence as a public health issue and the urgent need to develop responses for dealing with the same are being underscored internationally.

An overview of intervention programmes in India on women's health and violence against women

Gruesome cases of custodial violence and rape[8] in 1979 became the rallying points of the Indian women's movement. Since the 1980s, VAW—especially rape, sexual assault, and dowry-related violence—has occupied a prominent place on the agenda of the Indian women's movement, and has resulted in the adoption of key legislative amendments and new laws. Amendments to the rape law in 1983 and the adoption of the Dowry Prohibition Act in 1984 were significant milestones in the path towards securing gender-just laws. Since then, several women's groups and NGOs have been working with great commitment to provide support services to victims of violence. This includes medical aid, legal aid, alternative shelter, counselling services, and facilitating access to state-sponsored benefits. However, the explicit focus on linking health and VAW is more recent. As a result of large-scale research studies specific to India (International Centre for Research on Women, ICRW's multidimensional research programme spanning eight studies between 1997 and 2002; Jaswal et al. 2000; Jeejeebhoy et al. 1999; National Family and Health Survey (NFHS) 2001) and renewed international focus on the issue, the portrayal of VAW as a public health issue gained currency. The shocking decline in the child sex ratio in some states of India, revealed by the Census data of 2001, led to public interest litigation (PIL) cases that demanded greater state accountability in enforcing relevant laws and highlighted the importance of working with the health-care system in addressing the problem of sex selection, a gruesome form of VAW. More recently, the Domestic Violence Act came into effect in September 2005.

Prominent programmes that have integrated health care and VAW in India in the last decade include:

- **The DILAASA project:** One of the more notable interventions in this regard is the DILAASA project, a counselling centre set up in the K. B. Bhabha Hospital in Mumbai, Maharashtra. The project was implemented jointly by an organization called CEHAT

[8] For instance, the Mathura rape case and the rape of Ramiza Bee in Andhra Pradesh.

(Centre for Enquiry into Health and Allied Themes) and the Public Health Department of the Brihanmumbai Municipal Corporation (BMC). DILAASA is a one-stop crisis centre, and provides social and psychological support, legal assistance, and shelter services to victims of violence. In the course of running the cell, DILAASA staff members have been sensitizing hospital staff to the issues of gender and violence as well as training them to identify women facing domestic violence. Thanks to its success, the crisis-centre model has been replicated in two other hospitals in Mumbai and in a district hospital.

- **Innovative HIV/AIDS interventions** that have begun acknowledging and addressing VAW as a risk factor for HIV transmission are programmatically linking VAW and women's health. One such example is the CHARCA project, a joint UN programme on gender and HIV/AIDS in India, which is targeted at women and men in the 13–25 age group. It seeks to increase community awareness about HIV/AIDS and to develop an understanding of how lack of participation in decision making and the threat of violence places women at higher risk of HIV/AIDS. CHARCA is being implemented in six districts across India, and follows a two-pronged approach. First, it educates communities and women about HIV/AIDS, and increases the women's capacity to understand their rights and entitlements and to negotiate safe sex. Second, it also works with the government health system to make their services more gender sensitive.

However, at a programme and project level, attempts at integrating health and violence-prevention services have not taken place on the same scale as has been the case with legal aid and VAW. This is largely because of a lack of understanding about how the health-care system can address this issue, and also because of several competing demands on the health-care system.

UNFPA India country office's engagement with the issue of violence against women

The UNFPA India Country Office's engagement with the issue of VAW is informed by the objectives of its broader Sixth Country Programme (CP6), the operating mechanism for translating the vision of CP6, namely the Integrated Population and Development Programme (IPDP), the goals of the International Conference on Population and Development (ICPD), Cairo, 1994, and the existing policy framework of the Government of India.

UNFPA India: country assistance programme six (2003–07)

UNFPA India is currently implementing its Sixth Country Programme (CP6), covering the period 2003–07. The programme elements of CP6 have been designed to:

- Increase access to quality reproductive health;
- Prepare adolescents for adulthood;
- Highlight concerns of women;
- Advocate a rights-based approach in the health care system.

Evolved through a consultative process with state governments and health departments in six states, CP6 is informed by the programme of action adopted at the ICPD. Hence, facilitating the realization of women's reproductive rights is the cornerstone of UNFPA's work in India. The broad reproductive health agenda of CP6 is targeted at improving reproductive health choices for communities, but with a clear recognition that programming has to be geared towards understanding and addressing gender-specific needs and constraints.

At the same time, the policies of the Government of India—notably the National Population Policy 2000, the National Aids Prevention and Control Policy 2000, the National Policy for Empowerment of Women 2001, the National Health Policy 2002, and the National Youth Policy 2003—provide the broad policy framework for UNFPA programmes in India.

The integrated population and development programme of UNFPA and the work on violence against women

The UNFPA programme on VAW in India is an important dimension of CP6. It is being operationalized through the IPDP being implemented in six states—Gujarat, Madhya Pradesh, Maharashtra, Orissa, Rajasthan, and Kerala. UNFPA has been implementing IPDP in 32 districts and five municipal corporations across its six focus states in India since 1997. The programme was undertaken with the specific objectives of:

- Increasing access to and improving the quality of reproductive health services in project districts
- Empowering women to exercise choices, including those related to reproductive and sexual health matters
- Creating a programme environment sensitive to people's aspirations

In its second phase, IPDP includes a package of reproductive health services and initiatives aimed at giving women access to information and a role in programme management. It places strong emphasis on creating opportunities for

women through community empowerment and developing links with the health service system. Within this framework, UNFPA India has supported work at several levels—policy, programme, and project—to focus sufficient attention on the issue of VAW.

In 2005, UNFPA decided to support the sector-wide approach adopted by the Government of India in implementing Phase 2 of the Reproductive and Child Health programme (RCH2). It has pooled part of the resources of CP6 with the overall resources allocated by the government for implementing the programme. In doing so, UNFPA has moved from supporting projects in selected states to supporting the national RCH2 programme across the country.

At the policy level: The UNFPA India Country Office has collaborated with statutory bodies set up by the Government of India—the National Human Rights Commission (NHRC) and the National Commission for Women (NCW)—to promote policy dialogue on women's rights and on a life free of violence. At one such colloquium held in January 2003, deliberations on policies framed by the Union and state governments led to the adoption of a declaration on excluding discriminatory measures from population policies and affirming the significance of reproductive rights in promoting women's empowerment. In addition, UNFPA has also been working in tandem with the Ministry of Health and Family Welfare, Government of India to develop a national advocacy strategy on the pre-birth elimination of females (PBEF).

UNFPA has also worked in partnership with the NCW in developing a kit on VAW. The NCW is a statutory body set up by the Government of India to work actively with the government in strengthening legislative safeguards for women, facilitating redress of grievances, and advising the government on all policy matters affecting women.

The kit produced jointly by NCW and UNFPA includes the following material:

1. Violence against Women: A Health System Response: An information booklet for medical officers in the public health system.

2. Violence against Women: A Health System Response: A facilitator's guide for the orientation of medical officers in the public health system.

3. A poster on VAW.

The kit was released during a national-level workshop organized jointly by UNFPA and NCW. The workshop culminated in the adoption of a resolution calling for proactive measures for equipping the health sector in responding to VAW in an effective manner. The resolution specifically called for the institutionalization of screening protocols to detect violence, active mobilization of health care providers on VAW, and sensitization of front-line health workers, doctors, and government officials to the health consequences of VAW.

At the programme level: UNFPA and the Government of India have worked closely with the National Institute of Health and Family Welfare to mainstream gender issues in the training curriculum for health service providers. Additional components on gender and reproductive health have been added to the integrated skill training programmes for health service providers.

UNFPA has also provided inputs on adolescents and gender in the design of Phase 2 of the Reproductive and Child Health (RCH2) programme of the Government of India. Sensitization workshops for health service providers across different levels are being supported for recognizing the effects of gender-based violence on women's health and for ways of detecting and preventing abuse and assisting victims. These sensitization workshops have stressed the need for confidentiality and monitoring.

At the project level: The UNFPA India Country Office views violence as a significant factor impacting women's health. In an effort to position VAW as a public health issue, UNFPA has been supporting

State	Interventions	Site/Location
1. Maharashtra	❖ Aarohi, a hospital-based counselling centre ❖ 1 police station- based Special Cell for Women and Children ❖ 3 Family Counselling and Legal Guidance Cells located in an ongoing community development initiative	❖ Thane ❖ Ulhasnagar and Kalyan ❖ Pune, Bhiwandi, and Kalyan
2. Kerala	❖ Development of a protocol for the management of victims of VAW in the casualty department ❖ A district-wise resource directory providing information on support services available in each district of Kerala state	❖ Thiruvananthapuram ❖ All districts of Kerala state
3. Madhya Pradesh	❖ 5 FCCs located in police stations	❖ Chhattarpur, Satna, Rewa, Panna, and Sidhi
4. Rajasthan	❖ 8 family counselling centres located in district hospitals	❖ Udaipur, Rajsamand, Alwar, Karauli, Sawai Madhopur, Bhilwara, Chittorgarh, and Bharatpur
5. Orissa	❖ Help desks for women and children in 40 police stations across the state	❖ Spread across the state

special programmes aimed at highlighting the problem and supporting ways of addressing it. These interventions are being implemented in the states of Kerala, Madhya Pradesh, Rajasthan, Maharashtra, and Orissa. Given below is a brief description of the initiatives studied.

Documentation of UNFPA and state government-supported projects on violence against women

UNFPA has been supporting interventions aimed at addressing VAW in the states of Madhya Pradesh, Orissa, Gujarat, Maharashtra, Rajasthan, and Kerala. These interventions focus on strengthening institutional and community mechanisms to address VAW as a public health issue. UNFPA India commissioned a documentation and review study of these projects in March 2006 with the purpose of gaining key insights into the functioning of the interventions and culling out the lessons learned in implementing them.

The documentation was undertaken with the following objectives:

1. To undertake process documentation of the pilot interventions on VAW being supported by UNFPA in the states of Rajasthan and Maharashtra
2. To analyse the strategies adopted in operationalizing these strategies
3. To review the lessons learned, and to assess the successful and promising practices in implementing the interventions
4. To discern signs of change
5. To review the challenges and constraints faced in grounding such interventions
6. To identify the programmatic and policy implications emerging from these interventions

Methodology

The review was undertaken through field visits to the interventions to observe the functioning of the FCCs and to conduct in-depth interviews with key individuals within the government and from amongst the implementing partners as well

as UNFPA. The specific interventions visited for the purpose of the documentation included:

- The FCCs located in the district hospitals of Alwar and Karauli districts of Rajasthan state
- Aarohi, a counselling centre located in the Chhatrapati Shivaji Maharaj Hospital, Kalwa, Maharashtra state
- The Family Counselling and Legal Guidance Cell located in Pune, Maharashtra state
- The two Centres for Women and Children Victims of Violence: one is located in the office of the Deputy Commissioner of Police in Bhiwandi, and the other is located in the Rukmini Bai Civic Hospital, Kalyan, Maharashtra state.

Documents utilized for reference The documentation was undertaken using primary and secondary data. The documents reviewed included:

a) Periodic reports submitted by the implementing partners to UNFPA

b) Proceedings of workshops and training programmes

c) Evaluations of UNFPA's other international interventions on VAW

d) Background literature on implementing partners

e) Existing reviews and documentation of the interventions supported by UNFPA India.

Interviews and group discussions were undertaken with a range of stakeholders as well as staff members from amongst the implementing partners as well as UNFPA, across different levels. These included:

- Counsellors
- NGO heads and staff members
- State Programme Coordinators of UNFPA Maharashtra and Rajasthan
- Programme Officers of UNFPA in Delhi, Thane, and Rajasthan
- Assistant Representative of UNFPA
- Doctors
- Paramedical staff, such as nurses, ANMs, and VCTC counsellors
- District health officials, including the Reproductive and Child Health Officer (RCHO); the Chief Medical and Health Officer; the Hospital Superintendent; and the Primary Medical Officer (PMO)
- Clients who have accessed the services of the counselling centre

The broad domains of information covered through in-depth interviews, Participatory Rural Appraisal (PRA) exercises, and focus group discussions were as follows:

- Genesis of the intervention
- Approach and strategy adopted by the intervention to realize its mandate
- Milestones in operationalizing the intervention
- Signs of change emerging in response to the intervention
- Lessons learned in implementing the intervention
- Facilitating factors as well as key challenges and constraints

A brief description of UNFPA India country office-supported responses to violence against women

The UNFPA India Country Office has helped pilot several interventions on VAW, aimed at offering a coordinated and systemic response to the issue. Located within hospitals, police stations, and the general community, these interventions on VAW aim at strengthening the responses of formal institutions and seek to build their capacities in identifying and responding to cases of violence. Given below is a brief synopsis of the set of responses being implemented in each state.

Legal aid and counselling centres in the state of Maharashtra: addressing gender-based violence

Pursuing the goal of mainstreaming gender and empowerment concerns into the health-care system, the IPDP of UNFPA and the state government of Maharashtra identified VAW as a key issue that needs to be addressed through programme initiatives. Recognizing the acute social and economic vulnerabilities faced by women and children in slum communities, three approaches aimed at strengthening the response of the police, the hospital system, and the community at large were piloted in Thane, Kalyan, Bhiwandi, Ulhasnagar, and Pune.

- *Aarohi, a hospital-based counselling centre located in the Chhatrapati Shivaji Maharaj Hospital in Kalwa, TMC, Maharashtra.* Through the centre doctors and paramedics have been trained in identifying and referring cases of VAW.
- *Special cell for women and children attached to a police station in Ulhasnagar and Kalyan, Thane district, Maharashtra.* The cell facilitates women's access to police redress and sensitizes the police to make their services more gender sensitive
- *The Family Counselling and Legal Guidance Cell located within an ongoing community development initiative in Pune city, Bhiwandi, and Kalyan, Thane district, Maharashtra.* This programme aims at building social support structures for women by mobilizing community women and their families, community leaders, and opinion makers. It also seeks to capacitate women to increase their space and decision making within the family.

Family counselling centres in the state of Rajasthan

Rajasthan has witnessed one of the sharpest declines in the child sex ratio in the last decade because of prenatal sex selection. It is known for its strong patriarchal society and high rates of VAW.

The FCCs based in eight district hospitals in Rajasthan—at Udaipur, Rajsamand, Bharatpur, Alwar, Bhilwara, Karauli, Sawai Madhopur, and Chittorgarh—were set up on the premise that hospitals are key entry points for detecting and making relevant referrals for women facing violence. The objective of the FCC is to provide constructive social interventions through professional counselling, empowerment of women, and generation of awareness about gender equality. The FCCs receive cases through referrals by doctors and paramedical staff as well as other sources. Doctors, nurses, and community health workers such as auxiliary nurse midwives (ANMs) have also been trained to identify women who may be facing abuse.

Family counselling centres in Madhya Pradesh

With an increase in the number of cases of VAW in Madhya Pradesh, the government felt that it was necessary to set up legal redress mechanisms. Hence, the Madhya Pradesh police established 70 FCCs in different parts of the state.

UNFPA has lent support to five FCCs attached to police stations located in Chhattarpur, Satna, Rewa, Panna, and Sidhi. The counsellors at the FCCs provide counselling services and facilitate the woman's interface with the police in filing a complaint if she so desires. The location of the FCC within the police station and its close ties with police officials provides it with the mandate to intervene in cases of violence, and also enables it to negotiate with the perpetrators with the backing of the police.

The involvement of women counsellors with the police works well in most cases. The police provide the necessary power, infrastructure, and protection, while the counsellors provide help and support to the distressed woman.

Mahila and sishu desks: women's help desks in police stations in Orissa

Official records indicate that Orissa is predominantly both a source of and a destination for trafficking. At the same time, other forms of VAW are prevalent but are highly under-reported. One of the unique initiatives of the Government of Orissa to deal with VAW has been to establish help desks for women and children called Mahila and Sishu desks. The help desks are located within police stations, and function as a single-window institution where victims of violence can access support services.

It was planned to set up help desks providing round-the-clock services in all the 464 police stations in the state. Initially, help desks have been established in 40 police stations and a cadre of 100 help desk officers has been trained. The help desks were established under an order of the Home Department in March 2005. They combine the efforts of the Home Department and the Department of Women and Child Development to provide support to women and children.

The help desk is also meant to prevent trafficking in women and girls, and to rescue and rehabilitate them. A quick assessment of six help desks undertaken in August 2005 found that:

- The help desk has established close contacts with NGOs, the health department, and other agencies.
- Senior police officials such as the SP and the DIG have evinced a great deal of personal interest in making the help desk project a success.

Addressing gender-based violence under the IPDP in Kerala

A research study examining the nature, prevalence, incidence, and causes of gender-based violence in the state of Kerala was undertaken by a gender group called Sakhi, a resource centre for women, in Thiruvananthapuram. The findings of the study underlined the importance of health-system responses to violence, underscoring the need for specific protocols for screening women accessing the health system and for referring them to violence-redress services. The findings of the study led to the development of a comprehensive intervention model that would build support systems for women within the family, the community (including local self-government bodies and NGOs), the health system, and the criminal justice system. The results of the study were widely disseminated among various stakeholders in order to sensitize them about the nature of the problem and to build an agenda for action.

The results of the study have been:

- *The development of a protocol for the management of victims of VAW in the casualty department;*
- *The creation of a district-wise resource directory providing information on support services available in each district of Kerala.*

Considering the decision of UNFPA to pool its resources with those of the Government of India under the RCH2 programme, it was decided that these planned interventions would be undertaken under RCH2.

Specific activities planned for addressing VAW under RCH2 in Kerala:

- Orientation of health service providers on VAW
- Development and administration of protocols for screening and management of VAW
- Development and implementation of Health Management Information System (HMIS) to gather data on the incidence and prevalence of VAW
- Development of appropriate networks and linkages to address the issue in the piloted districts
- Sensitization of police personnel
- Strengthening of community-based support systems and vigilance committees
- Review of the criminal justice system
- Establishment and functioning of counselling centres for women victims of violence

The interventions outlined above are attempts to institutionalize a coordinated response to VAW. The positive fallouts of these interventions (such as increased sensitization of the health-care system; a well-equipped referral system; enhanced capacities of women to take decisions; professional services for therapeutic counselling; and the creation of broader community support) have resulted in several of these being taken over by the state government under RCH2. These interventions are slated to continue despite the withdrawal of direct support from UNFPA. Notable among these are FCCs in hospitals and community settings.

UNFPA supported hospital-based family counselling centres

UNFPA is supporting hospital-based FCCs in eight district hospitals in Rajasthan, one municipal hospital in Thane, Maharashtra, and one district hospital in Chandrapur, Maharashtra. Included in this section is an analysis of the following FCCs:

a) The FCC located in the district hospital in Alwar, Rajasthan

b) The FCC located in the district hospital in Karauli, Rajasthan

c) Aarohi, the Counselling and Legal Aid Centre for Women Facing Violence, located in the Chhatrapati Shivaji Maharaj Hospital, Kalwa, TMC, Maharashtra

Introduction

'Doctors did not know what to do when faced with a case of violence amongst their patients. The Kendra has filled this gap.'

Counsellor from the FCC in Alwar

Hospitals are often a neglected but significant 'catchment area' for detecting and responding to women who may be victims of violence. The FCCs located within eight district hospitals of Rajasthan and in the Chhatrapati Shivaji Maharaj Hospital, Kalwa, TMC, Maharashtra are filling a critical gap in this regard. According to the staff at Aarohi (the FCC located in Thane), women facing violence are more likely to access health services (though not necessarily for redress of violence), and at an earlier stage, than they are likely to seek police assistance. Thus, the health system is an excellent entry point for detecting and responding to VAW. This has been one of the compelling reasons for setting up a counselling centre within a hospital setting.

Here is a brief description of the FCCs in Rajasthan and the Aarohi centre in Thane, Maharashtra:

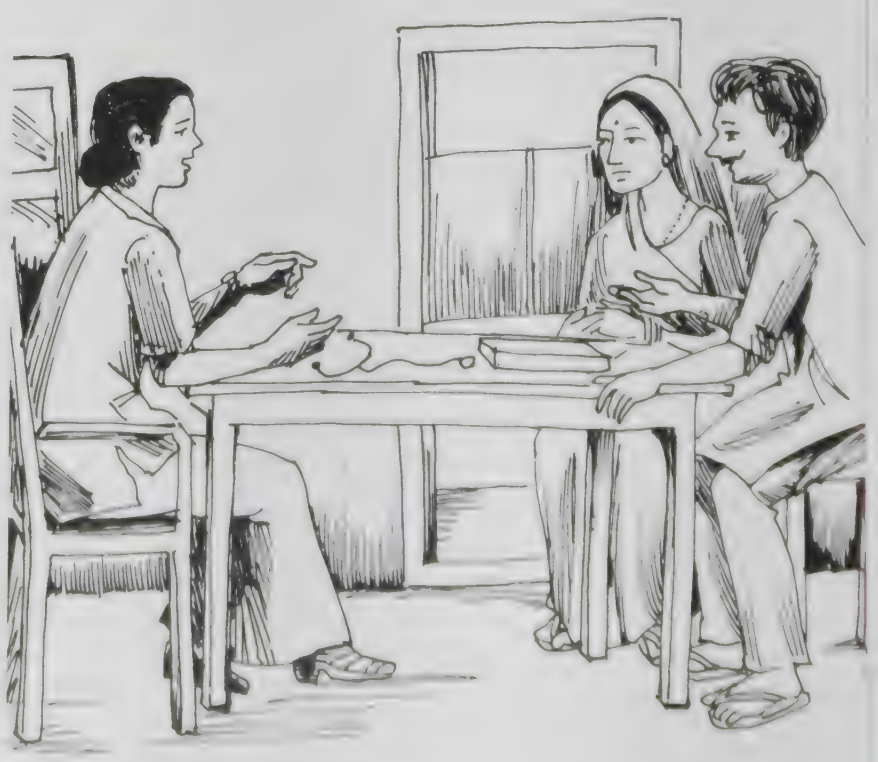
Aarohi

Implementing partner

Tata Institute of Social Sciences (TISS), Mumbai.

Description

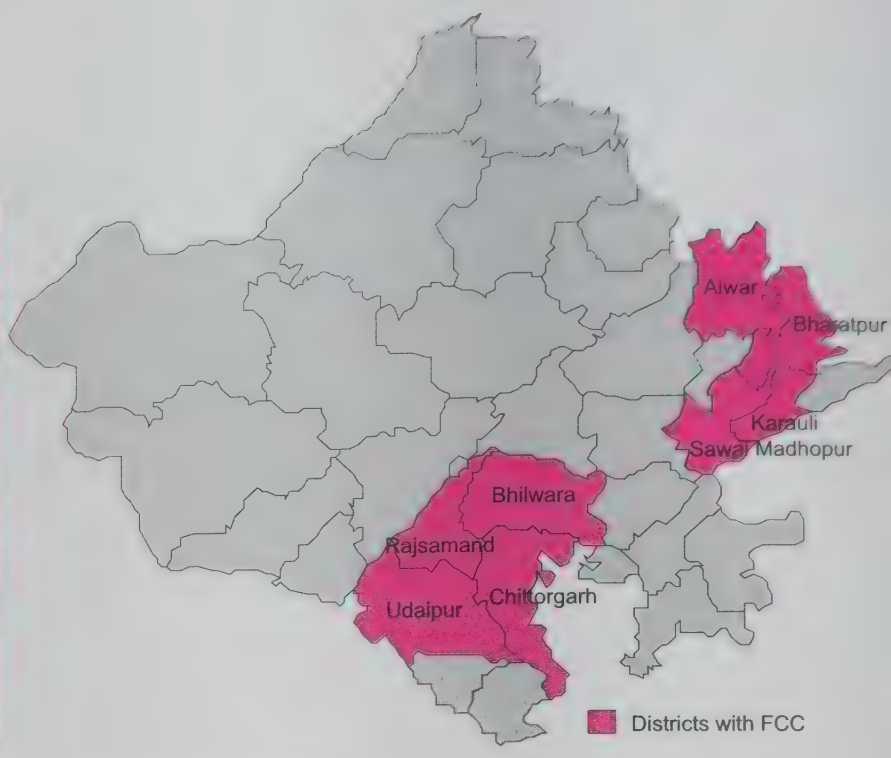
The FCC in TMC, Maharashtra, which was set up in 2001, is located at the Chhatrapati Shivaji Maharaj Hospital, a municipal hospital located in Kalwa, adjacent to Mumbai. The implementing partner of Aarohi is TISS, Mumbai. It was managed initially by a staff of four—one project coordinator and three counsellors. At present, it is being managed by two counsellors. A separate room has been allocated within the hospital for the centre, and basic infrastructure—in the form of private seating facilities for the client and a telephone—has been made available.



FCCs in Rajasthan

Implementing Partners

District	Implementing partners / NGOs
Rajsamand	Mahila Manch
Udaipur	Mangal Murti Indira Gandhi Janata College
Alwar	Pragatisheel Mahila Manch
Karauli	ECAT Bodh Gram
Bharatpur	Sahyog Shikshan Evam Prashikshan Sansthan
Sawai Madhopur	Prakriti Society
Chittorgarh	Prayas
Bhilwara	Bal Evam Mahila Kalyan Society



Description

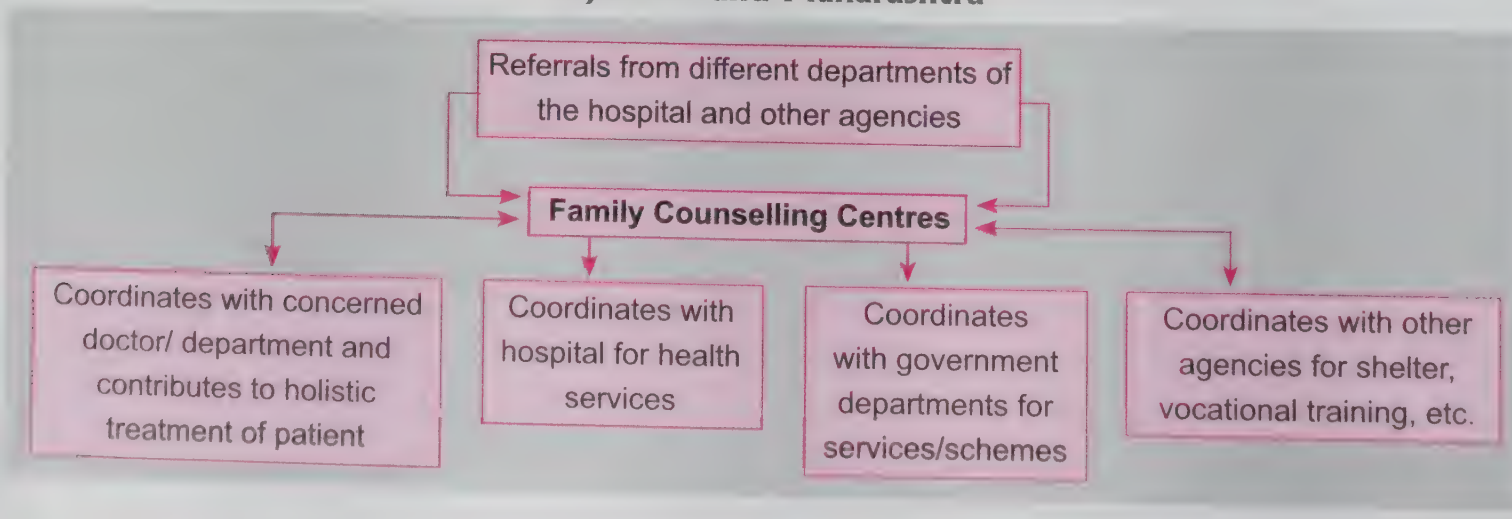
The FCCs have been operational in eight district hospitals for at least the last one year, and in a few places they are close to completing two years. In each district, an NGO partner was selected to implement the intervention. The FCC staff consists of counsellors. The partnering NGO plays a significant role in mentoring and providing technical guidance to the counsellors in their work. The FCCs have been allocated a separate room for their activities. However, their exact location varies from district to district. For instance, in Alwar, the FCC is situated within the Zenana Hospital, or a hospital dedicated only for female patients. In Karauli, the FCC is located within the Department of Obstetrics and Gynecology of the district hospital.

Advantages of locating family counselling activities within hospitals

- Hospitals are easily accessible to women as they are perceived as a 'neutral setting' by both women and the community; they are not traditionally associated with places where women go to seek help for violence redressal. Hence, women are able to access hospitals easily, especially in places like Rajasthan where women's mobility is severely restricted.

- Hospitals are devoid of the perceived stigma attached to approaching the police or a separate centre devoted to dealing with cases of VAW. In this sense, hospitals provide a safer setting for women desirous of seeking help.

Diagram showing the pathways of referrals operating in the FCCs in Rajasthan and Maharashtra



- The overall approach adopted by these interventions has been to utilize the hospital setting as an entry point to identify women who may be facing violence.

- Active linkages have been established between the FCC and various departments of the hospitals. Doctors and paramedics are being sensitized to identify women who might be facing abuse. Such women are then referred to the FCC.

- The FCC counsellors liaise with the concerned department in a given case and address the psychosocial needs of the woman through counselling and therapy.

- The FFC counsellors may also liaise with various departments of the hospital to facilitate clients' access to various medical services such as blood supply, subsidized treatment, etc.

- The FCC counsellors also network with other support agencies providing vocational training, residential schools for children, shelter, legal aid, etc.

Some common factors in the evolution of FCCs in the states of Rajasthan and Maharashtra

I. **The setting up of FCCs in both states has followed a consultative process:** The need for interventions such as the FCCs emerged from the broader agenda of UNFPA India CP6, which was developed through a consultative process. Key departments of the state government, such as women and child development and health and family welfare, were consulted in developing the plans of each individual state. Several civil society organizations and gender groups were also consulted. Through this entire process the need to include VAW as a key health issue found broad approval and agreement.

II. **The success of UNFPA-supported interventions on VAW in other states paved the way for the setting up of the FCCs:** UNFPA programme experiences of supporting FCCs in other states (Madhya Pradesh, for example) proved the viability of locating and implementing VAW interventions within the government system. These factors together paved the way for integrating violence-prevention services into the medical system. Resource agencies providing technical support and training and NGO implementing partners were identified for launching the initiative. The selected counsellors were oriented to the process of setting up and running the FCCs at a three-day training programme.

III. **Support of encouraging and sensitive state and district health officials:** From the policy level to the programme level, supportive government officials have played a significant role in the setting up and implementation of the FCCs. For example, the earlier Secretary of Health and Family Welfare of Maharashtra state was an extremely proactive civil servant with a strong commitment to gender issues. This led to not only mainstreaming of gender concerns within the health system but has also the design and institutionalization of screening protocols for victims of sexual assault. Similarly, the Principal Medical Officers (PMOs) in the Alwar and Karauli district hospitals in Rajasthan have extended a great deal of institutional support to the FCCs, and have also been advocating the work of the FCC counsellors.

At the operational level, this factor affects front-line workers and counsellors in a close and very immediate way. A supportive government official can smoothen several administrative hurdles for the counsellors and become an advocate in sensitizing others within the health system. On the other hand, dealing with officials who view VAW as purely a law-and-order issue can undermine the work of the FCC and the counsellors.

This factor also points to the ground realities and challenges in institutionalizing such interventions. The experience of development planning in general, and of introducing programmes on gender issues in particular, has shown that in spite of the best efforts aimed at integrating interventions within government systems, at the ground level, it is the vision and sensitivity of the officials supervising and supporting the interventions that determine their success.

IV. **Sound implementing partners:** The technical expertise and credibility of the implementing NGO has contributed enormously to the acceptance of the FCC within the health system and to its success. In Alwar and Karauli districts in Rajasthan, for example, the implementing partners—Pragatisheel Mahila Manch (PMM) and the Society for Education Conscientisation Awareness and Training (ECAT) respectively—are NGOs of strong repute, and both have a good community presence. ECAT, for instance, has been working in the district for more than a decade. It works on a number of issues such as education, livelihoods, and women's empowerment. In this context, it has engaged with several departments of the government, and is well known to officials and others. PMM in Alwar has been in existence since 1988. Its members have very close links with the police. Their rapport with senior police officials enables them to seek police action from higher authorities in resolving cases as opposed to having to cajole and convince junior police officials, who, according to the NGO workers, are far more rigid. Similarly, Aarohi in the Thane Municipal Hospital of the Thane Municipal Corporation, TMC, has been set up and is technically supported by TISS, Mumbai, an institution of high repute and good standing in academic circles, with responsibility for supervising several field action projects.

V. **Skills and abilities of the counsellors:** The growing acceptance of FCCs can be attributed to the sound professional expertise and commitment of the counsellors. In Thane, for instance, FCCs are being managed and run by extremely skilled counsellors. They follow a woman-centred approach to counselling, and have succeeded in providing a *strong therapeutic and mental health angle to the intervention, thus positioning the centres as 'health service providers'.*

Evolution and growth of FCCs in Rajasthan: social context and policy environment

The broader policy environment on health and development in the state of Rajasthan is heavily focused on the greater involvement of women, with large sums of money being earmarked under RCH2[9] for reaching out to women in order to increase their access to RCH services, to reduce maternal mortality, and to increase coverage of immunization. The current chief minister of Rajasthan is a woman who is deeply committed to women's participation in every sphere.

[9] RCH² is Phase 2 of the Reproductive and Child Health (RCH) programme of the Government of India (2005–10).

Several initiatives at the district level have also placed VAW as an important item on the development agenda. For instance, every district is expected to set up a Mahila Sahayata Samiti (Women's Assistance Council), to be led by the District Collector. The purpose of this council is to provide support and immediate relief services to women in distress. Similarly, the state has launched a scheme to provide monetary benefits to families with girl children. In Alwar district, the Deputy Inspector General (DIG) and the Superintendent of Police (SP) are very proactive in this regard. They have instituted the setting up of a women's help desk at every police station in the district.

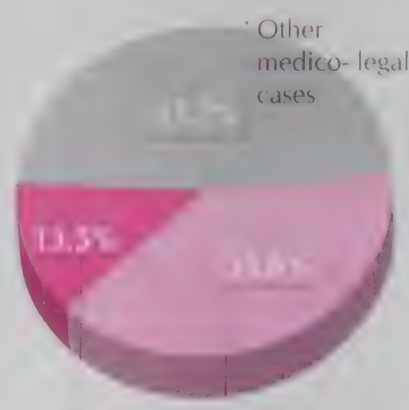
Rajasthan has also come under government scrutiny due to the state's falling sex ratio and the abysmal child sex ratio as revealed by the 2001 Census, thus drawing national and international attention to prenatal sex selection as a matter of deep concern. The number of internationally funded programmes on VAW have been increasing for the last three years in the state. Rajasthan also boasts of very active women's groups, a wide civil society platform, and a history of innovative educational programmes, some related specifically to women's empowerment (Women's Development Programme of the Government of Rajasthan). Through the IPDP supported by UNFPA, an excellent rapport and deep trust have been established by the state office with the district administration, resulting in greater openness to newer perspectives on health. However, according priority to issues such as violence within the area of public health has been, and continues to be, a challenge.

Growth and evolution of FCCs in Maharashtra: social context and policy environment

Successive state governments in Maharashtra have been actively engaged for several years with civil society groups on many issues, including women's rights. The Brihanmumbai Municipal Corporation (the Municipal Corporation of Mumbai) has also partnered with an NGO in running a crisis centre for women in distress[10] through international donor support. There is also a strong people's health movement in the city. Maharashtra has a history of adopting several positive measures for enhancing women's status; it was among the first states to draft a policy for women. The FCC Aarohi in Thane is urban based, and has benefited from the broader positive and proactive development environment peculiar to the metropolis.

The genesis of Aarohi, the FCC in the Municipal Hospital in Kalwa, can be traced to a research study undertaken at the hospital by TISS, Mumbai, a premier teaching and research institution in India, which also implements several field action projects. This research study (Jaswal et al. 2000) examined the case records of 2,047 medico-legal cases at the Chhatrapati Shivaji Maharaj Hospital, Thane district and 10,616 cases from health outposts of Thane to investigate the prevalence of domestic violence in health-care settings. Hospital records were analysed to detect domestic violence cases within hospitals. This study showed that the actual detection of domestic violence as a cause of injury is very low. Domestic violence as the cause of injury and trauma was mentioned in only 13.5 per cent cases. The researchers found that in an additional 38.8 per cent cases, women were most likely victims of domestic violence, but this was not reflected in the hospital records. The findings of this study compelled TISS to initiate a field action project for providing counselling services within the hospital to women facing violence. UNFPA's support was timely, and Aarohi was established in 2001.

Prevalence of domestic violence in health-care settings in Thane



Reported cases of domestic violence as the cause of injury and trauma

Victims of domestic violence, but not reflected in hospital records

[10] The DILAASA project, which has been described earlier

The journey so far by the FCCs in Rajasthan and by Aarohi in Maharashtra

The section below describes the approach and strategy in instituting the FCCs as a part of the health-care system: (a) the strategy adopted; (b) the challenges encountered; (c) the signs of change experienced; (d) the constraints faced; and (e) the lessons learned in the entire process.

The broad operational steps in setting up the hospital-based FCCs in both Rajasthan and Maharashtra have been:

I. Consultations with the Health Department and the Department of Women and Child Development at the state level for the establishment of FCCs

II. Identification of implementing partners

III. Facilitating establishment of the FCC infrastructure

IV. Orientation of various stakeholders within the hospital and external agencies regarding the FCC

V. Training and capacity building of the FCC counsellors

VI. Development of MIS formats

VII. Outreach activities

Approach and Strategy for Creating a Mandate for the FCC

The overall strategy of building ownership for the FCC within the hospital has been similar in Maharashtra and Rajasthan in spite of the varied contexts. The counsellors have worked very hard to increase the visibility of the centre and demonstrate the 'value added' by it. In doing so, strategically, they did not confine themselves only to casework. They also began serving as intermediaries between the hospital and the patients, facilitating access to various medical services such as subsidized treatment and blood supply, making women aware of government health schemes, etc. In this way, they began contributing to the overall health-delivery process of the hospital. This enabled them to increase their rapport with the hospital staff, and also opened avenues for interacting with doctors and paramedics for sensitizing them on issues of VAW.

The counsellors at Aarohi have to be assertive yet accommodating in their relations with the health system. According to Aparna Joshi, 'We talked to the doctors using medical language.' Thus, they proved that they understood the medical sciences. Establishing one's professional credentials was an important step in building trust and credibility within the health-care system.

Some of the specific measures taken by the FCC counsellors to integrate themselves into the hospital system include:

- Making the rounds of all departments on a regular basis in order to identify possible cases of violence. The counsellors also used this opportunity to offer patients information on a range of issues, such as the medical facilities available at the hospital and special services for the underprivileged.

- Organizing for the immediate medical needs of patients, such as blood and free medical check-ups.

- Addressing other 'ancillary' needs that contribute to the overall health of women, such as facilitating access to iron and calcium supplements and counselling them on female-controlled contraceptives in cases where women have reported lack of cooperation on the part of their husbands.

- Liaising with the police on specific cases, especially when the woman has been abandoned, and in cases of rape.

- Discussing specific cases with doctors and offering their own assessment about the causative social factors affecting the patient's health.

- Organizing events for special occasions, such as World AIDS Day, and seeking the active involvement of doctors.

- Seeking out and cultivating positive professional relationships with the permanent staff of the hospital who can become advocates for the issue and the centre.

- Building strong links with sensitive doctors and paramedical staff.

Sensitization of stakeholders within the hospital system

Sensitization of key stakeholders within the hospital, such as doctors and paramedical staff, as well as secondary stakeholders, such as the media, has been far more systematic and planned in Maharashtra than in Rajasthan. In Alwar district, Rajasthan, for instance, it has not been possible to follow up an initial sensitization programme for doctors and paramedics with more sustained and systematic training and sensitization programmes.

The counsellors at Aarohi began writing their observations on the case papers of in-patients. This enabled the doctors to understand the psychosocial assessment being undertaken by the counsellors, and this also subtly established their mandate in working alongside the doctors in dealing with a case.

The FCC counsellors in Alwar visit the wards when the doctors are on their rounds. 'The doctors tell us about cases and also seek help from us. We also carry posters about the centre when we meet them,' says Babita, an FCC counsellor.

This has largely been due to budget constraints. On the other hand, at Aarohi in Thane, Maharashtra, sensitization of doctors was planned through trainings and exposure to issues of gender discrimination during key events. The counsellors at Aarohi opined that sensitization itself is a process-driven exercise and cannot happen only through formal training programmes.

In Karauli district, Rajasthan, sensitization of doctors and other medical staff has been mainly through one-on-one interaction with them and through presentations. Administrative delays and the transfer of doctors have stalled the sensitization programmes planned by the FCC counsellors. However, the counsellors here have actively disseminated information about the FCCs in training programmes held for ANMs, sahyoginis (field-level functionaries responsible for delivering various government programmes in the field), and anganwadi workers (AWWs).

Approach and strategy versus the counselling process: a women's centre model of counselling adopted by counsellors at the Aarohi counselling centre

The counsellors at the hospital-based FCC Aarohi located in the Chhatrapati Shivaji Maharaj Hospital, Kalwa, Thane district, Maharashtra state, are passionately committed to creating space for women, privileging their voices and experiences, and facilitating a process of self-determination and empowerment for women. The Aarohi counselling centre adheres to a set of principles in their counselling process that they describe as women centred. These principles have been derived through a process of reflection and analysis of the counsellors' experiences of casework.

The process of counselling described below captures some of the 'non-negotiables' adopted by the counsellors at Aarohi. The key features of this model are:

- **Listening to the woman's story:** Avoiding the tendency to justify or rationalize the violence in any way, providing a non-judgmental space for women where they are accepted unconditionally, ensuring privacy, and protecting the confidentiality of the transaction are the key elements of the counselling process at Aarohi.

- **Exploring the problem areas that need to be worked on:** The woman often faces many problems. Apart from violence, she may have a physical or mental health problem, financial crisis, concerns about her own personal safety or the safety of her children, etc. Exploring the problem areas and prioritizing these concerns becomes important in understanding the immediate and long-term concerns of the woman.

- **Making the woman aware of her rights:** Creating awareness about gender injustice, the cycle of violence, and a woman's right to emotional, physical, and sexual health as well as her right to a violence-free life are integral elements of the counselling process at Aarohi.

- **Preventing further episodes of violence through self-defence:** This involves an assessment of incidents of violence and abuse, the nature of the violence (physical, verbal, sexual, mental, and/or economic), trigger factors, frequency of violence, etc. The counsellors work with the woman in delineating the patterns of violence and equipping the woman to break the same. This preparation plays a crucial role in the woman's self-defence and in the prevention of further episodes of violence.

- **Working out a safety plan:** Exploring the options available should the client desire to leave home, or if she is forced to leave home under unforeseen circumstances, and planning for her exit is an important part of strategizing, according to the counsellors at Aarohi. The importance of carrying all the important documents in case the woman desires to leave her home, such as the ration card (which ensures access to grains and other supplements under the public distribution system), evidence of marriage, school and college certificates, etc. is emphasized by the counsellors during this stage.

- **Improving the woman's self-image and self-confidence:** The pro-woman approach of the counselling process at Aarohi seeks to improve the self-image and boost the self-confidence of the woman, making her view violence as something that she can resist and combat. Shanta Bai's case study in Annexure II illustrates this point.

- **Encouraging the woman's participation in the decision-making process:** All decisions regarding the course of action are taken by the woman, with the counsellors extending emotional support, providing information, and pointing out the likely implications of the actions. The woman is thus expected to think through and make the decision on her own and to take responsibility for the same.

- **Helping the woman attain economic independence:** Working for economic independence by helping the woman fight for her economic rights either at her natal or matrimonial family, as well as finding self-employment or employment opportunities also forms an integral part of the counselling and problem-solving process.

- **Providing the woman shelter for 48 hours:** Two beds in the psychiatry ward of the hospital have been reserved for emergency admission of women visiting Aarohi who cannot go back home and who need temporary shelter before an alternative shelter is found. This has proved particularly advantageous as getting admission in shelters at night is difficult.

Operationalizing hospital-based FCCs: points of coordination and points of tension with the health system

A. **The strategies employed by the implementing partners in working with the health system have been highly contextual:** The FCCs are engaged in various tasks designed to make their presence felt within the hospital and to establish their mandate, such as coordinating with the hospital system, sensitizing health personnel, and making the health system more accountable in detecting and referring cases of violence to the appropriate agency. Given the complexity of this mandate, the implementing agencies have adapted their own set of strategies for sensitizing, and at times pressurizing, the health system to pay more attention to the issue of VAW. The implementing partner in Alwar district, Rajasthan, for example, is more inclined to use its existing goodwill and networks with senior police officials, doctors, and other agencies in dealing with cases of VAW.

In the adjoining district of Karauli in the same state, the implementing agency, ECAT, is a larger NGO with a strong activist base. They have used the media strategically to focus public attention on issues of civic interest and to galvanize the district administration, including the hospital set-up. They have approached the State Commission for Women in specific cases where they have felt that government involvement needs to be more substantial.

At the Aarohi counselling centre located in TMC, Maharashtra, the approach has been to build space for the intervention within the system by adapting its language and by demonstrating high technical competence that supplements medical treatment.

Each of these strategies is highly context specific and highlights the complex environment in which medical and social responses are integrated.

B. **Addressing VAW means addressing the underlying causes of women's poor health:** It is extremely important for the health-care system to recognize and understand that VAW falls at the end of a long continuum of gender discrimination and vulnerability that threatens women's health status. Therefore, reducing VAW means improving the overall environmental context that affects women's health. If the ultimate goals of good health are productive human beings and equitable development, then violence acts as a serious obstacle to the achievement of these aims.

C. **Attempts to identify linear and cause–effect relationships between reduction in VAW and better health outcomes is a limiting approach to the issue:** Health service providers very often seek justification for how reduction in VAW can lead to 'better health outcomes' since that is the ultimate goal of any treatment process. When the health sector responds to VAW, it mitigates and addresses factors in a woman's life that lead to poor health. Reducing violence has long-term and short-term effects, such as direct and indirect health benefits for women and children. The long-term beneficial outcomes include a positive environment that improves mental and physical health, leads to generations of healthier and more productive individuals, and lower caseloads. More direct and short-term positive outcomes include increased use of contraception, fewer complications during pregnancy, and improved birth weight. Even these short-term benefits can be demonstrated through longitudinal studies, but only if violence-reduction interventions have been functional for a substantial period of time and if such outcomes have been measured rigorously through high-quality operations research.

D. **In situations where violence is the root cause of or a contributing factor to a woman's illness, failure to address the issue would amount to partial or incomplete treatment**. At the same time, it is unrealistic to expect that doctors and other health-care providers should offer counselling services to victims of violence, especially in a poorly equipped hospital set-up, which also has an extremely high caseload of patients. However, given the position of power that doctors command in society, they are well placed to ask questions and to screen women for the presence of violence as a determining factor in their health condition. Hence, a support service such as the FCC, which works alongside doctors to alleviate situations of violence, is of great value.

Signs of change

The section below discusses the signs of change that have become evident as a result of the intervention of hospital-based FCCs. However, this analysis needs to be read with the following caveats in mind:

- Apart from the Aarohi Counselling Centre in Kalwa and TMC of Maharashtra, which was established in 2001, the FCCs in Rajasthan have been functioning for periods ranging from one to one and a half years. Therefore, what is visible at this point in terms of change may at best be described as emerging signs. Most of the stakeholders also felt that it is too early to look for lasting change at this stage.

- There is insufficient data for undertaking a quantitative analysis over time. The MIS as it is currently structured does not lend itself to an in-depth analysis of change over time. This is a significant gap in the current monitoring system.

- **Change in the levels of sensitivity of hospital staff and increasing referrals from various departments of the hospital:** A subtle but significant change that has been reported by the counsellors at Aarohi and the implementing NGO partners in Rajasthan is a shift in the attitude and sensitivity levels of doctors and other paramedical staff towards gender issues and VAW.

> 'The attitude of the PMO has become more positive as he saw committed staff working at the FCC and because there is a definite place where they [the doctors] can send the women.'
>
> *Counsellor at FCC, Alwar*
>
> 'There has been a drastic change in the referral of doctors over the last five years.'
>
> *Ms Pragnya, counsellor, Aarohi*
>
> 'Earlier, the doctors did not pay attention to DV [domestic violence] and were not aware of Aarohi. But now the situation is different. They probe when required, and provide medical and psychiatric treatment before referring the women to Aarohi. Even the police are more sensitive to the issue, and are extending their cooperation to the centre. Developing a protocol is important for identifying cases of DV. However, lack of coordination between the various departments is a problem.'
>
> *Dr Sawant, Superintendent, Chhatrapati Shivaji Maharaj Hospital, Kalwa, TMC, Maharashtra*

According to the counsellors in Alwar, Karauli, and Aarohi, after the FCC came into existence, doctors became more alert in watching out for tell-tale signs of violence and now refer cases to the FCC more regularly than before. However, referrals by doctors have not been uniform across all departments. In the Zenana Hospital of Alwar district, Rajasthan, it is the psychiatrist and the ENT specialist who refer more cases, while in the Karauli district hospital, the largest number of referrals come from the departmentof Obstetrics and Gynaecology.

Counsellors at the Aarohi counselling centre run by TMC of Maharashtra have reported receiving cases from virtually all departments. They also have a strong link with the HIV Voluntary Counselling and Testing Centre set up in the hospital. This is also partly due to the fact that the Voluntary Counselling and Testing Centre at the Chhatrapati Shivaji

Maharaj Hospital was initially supported under the IPDP of UNFPA. Hence, the convergence has been more pronounced. However, this is not really true of the FCCs in Rajasthan.

According to the FCC counsellors in Maharashtra, the reasons for the change in the attitude of doctors and paramedics are:

- The dedication and zeal of the counsellors
- The professional skills of the counsellors in handling cases
- Successful outcome of cases
- Increased sensitivity of doctors to these issues through exposure to key events and interaction with FCC counsellors.

A Caveat

It is important to note here that the services of the FCC are being utilized more by those doctors and paramedics who already have an existing inclination to delve into these issues. Given the time period over which the FCCs have been functioning, it is probably too early and unrealistic to look for 'radical converts' within the health-care system. The FCC is of great use and value to those who are tackling issues of violence in the lives of their clients but who do not know how to deal with them or where to refer them. It is such advocates who need to be guided in institutionalizing their response more thoroughly, and also for converting others in the medical fraternity. While the FCCs are doing this, this intervention is not a consciously articulated strategy for institutionalizing the response uniformly. In Thane, it was planned carefully and was implemented in a well-thought-out manner.

- **Changes in the engagement of implementing partners/NGOs with the issue:** According to Dr Shachi Arya, general secretary of the PMM, the NGO implementing partner managing the FCC in the district hospital in Alwar, the FCC has enabled the organization to work more systemically on the issue of VAW. The PMM is an issue-based organization that has kept itself away from project funding, but has been raising the issue of women's rights for several years in the district. Through the FCC, their engagement with the police has increased and become more formal. According to Dr Arya, the FCC is able to secure more cooperation from the police as the latter have become aware and appreciative of the FCC's sensitive handling of cases. 'Earlier our involvement (with the police) was based on personal credibility. Now it is more systemic,' she says.

- **The FCC is seen as a reliable service because of which the hospital personnel feels motivated to identify and refer patients:** The FCC is playing a very significant role in channelling and providing a reliable service for doctors to refer their patients. It is important to note that insensitivity is not the sole reason that prevents doctors from asking their patients about their experience of violence. It is also because most of the times the doctors feel ill-equipped to respond to such situations. This understanding is an important starting point in developing strategies aimed at involving the health-care sector. As Babita, a counsellor at the FCC in the Alwar district hospital, pointed out, 'It is not that doctors are not sensitive, but they do not know what to do (when confronted with cases of VAW). Limited human resources means that doctors are inhibited in asking too many questions about such issues as they

> 'When women in the field share their problems with us, we refer their cases to the FCC. I have referred five cases so far. People have become more aware of these issues and feel reassured that the FCC will help them. The FCC is a positive development in the hospital.'
>
> *Ms Sudeshna, ANM, Karauli*

Counselling centres have begun receiving cases from health service providers. ANMs and nurses have been approaching the FCCs for counselling intervention.

have to handle several patients.' At the same time, the FCC in Alwar has formalized a set of responses that doctors are expected to adopt or display when they come across cases of VAW. According to the counsellors, this also makes them more accountable. 'Doctors follow up the cases that we refer to them' (Sushma, NGO worker, PMM, Alwar).

- **Change in the number and nature of cases:** The counsellors have reported a substantial increase in the caseload at the counselling centres in Rajasthan and Maharashtra. The table below shows the increase in the number of cases between December 2004 and December 2005. The FCC located in the district hospital in Karauli, Rajasthan has reported receiving cases from both far-flung villages and nearby districts. Doctors are not the most common source of referrals, however, in the hospital-based FCCs in Rajasthan. Former clients, paramedical staff, and self-referrals constitute a relatively larger source of referrals. According to the counsellors at Aarohi, the bulk of referrals have over time become hospital driven. However, empirical data to substantiate this claim are not available.

- **Personal changes reported by the counsellors as a result of their involvement with the Counselling Centre:** The counsellors handling complex cases and dealing with a complex system have reported several personal changes that they have experienced in the process of running the FCCs. 'I motivate my own family members not to put up with similar problems,' says Ms Babita, counsellor in Alwar. Ms Santosh, the counsellor in Karauli, has observed a distinct change in the attitude of her male counterpart counsellor (Mr Arvind) as a result of their exposure to gender-based violence and discrimination through their work. 'He helps his wife around the house much more than before,' she observes. According to Ms Manisha Joshi and Ms Pragnya, one of the most significant results in their lives has been the evolution in their own understanding of violence, its causes and effects, especially on women.

The counsellors at the FCCs located in the district hospitals in Karauli and Alwar, Rajasthan have also reported a change in the nature of cases being received. 'Earlier we were receiving more medical cases,* whereas now we are getting more cases of VAW' (Sushma, NGO worker, PMM, Alwar district, Rajasthan).

The 'value added' by integrating FCCS within a hospital set-up

An important assumption that has been validated through the hospital-based counselling centres discussed in this section has been that integrating services on VAW within hospitals helps in

Cases received between December 2004 and December 2005 at six family counselling centres located in District hospitals in Rajasthan state

District	Dec 2004	Jan	Feb	Mar	Apr	May	June	Jul	Aug	Sept	Oct	Nov	Dec 2005	Total
Udaipur	1	2	3	4	4	2	2	10	5	2	5	7	7	54
Alwar	2	14	19	12	17	13	8	7	12	10	7	8	10	139
Karauli	0	1	27	25	28	48	21	37	30	56	40	40	45	398
Sawai Madhopur	-	-	-	-	-	-	-	8	16	5	5	8	7	49
Chittorgarh	-	8	10	13	26	12	20	13	17	19	6	8	5	157
Bhilwara	5	7	7	19	4	4	13	22	20	25	18	16	14	174

* Medical cases are those where the client essentially wants facilitation for accessing the medical services of the hospital, such as free medicines, subsidized check-ups, and medical tests.

identifying women who may be facing abuse but who may not necessarily be seeking help from any external agency in dealing with their situation. In this sense, hospitals are potential catchment areas for detecting and addressing cases of VAW. According to the counsellors at the FCCs in Rajasthan and Maharashtra, women choosing to approach the police or legal aid centres for redress of abuse are making a conscious choice to seek help. More often than not, approaching the police or the courts is the last option, and takes place after the woman has faced considerable abuse for a prolonged duration. However, women reach out to hospitals for medical treatment, not violence redress. If violence is found to be a contributing factor to the woman's illness, and if the FCCs are able to address this problem, it amounts to detecting cases at a relatively early stage. Hence, according to the counsellors, hospitals and other health set-ups are well positioned to detect cases of VAW much earlier and to help women access the required support.

The decision to locate the FCCs within hospitals has led to the evolution of a health-sector response in more ways than one.

- On the one hand, *it establishes the legitimacy of violence as a health issue* by building active linkages between the medical fraternity and the violence service providers.

- On the other hand, it also *expands the range and scope of what constitutes 'health services'*. The notion of health itself is a multidimensional one,[11] and violence in any form is a serious obstacle to the mental health and well-being of both victims and perpetrators. Hence, a violence-redress service within hospitals is a way of acknowledging the physical and mental health consequences of VAW.

- Dr Saxena, an ENT specialist based in the Zenana Hospital, Alwar district, Rajasthan state, calls the FCC the 'helping hands of the hospital'. He adds, 'We (doctors) cannot engage with these issues in the same way as they (the FCC) can.' He says that in 25 to 30 per cent of the cases handled by him domestic violence plays a role in causing the injury. 'Domestic violence exacerbates the existing (medical) condition,' he observes. According to Dr Saxena, the advantage of having an FCC within the hospital is that he is able to refer the cases that he cannot handle himself, especially cases of alcohol abuse. The consulting psychiatrist, Dr Sharma, supports this view. 'Earlier I used to counsel the patients (on VAW issues) myself, but now a separate set-up has made this easy. We do not have adequate time,' he says. According to Dr Sharma, approximately 50 per cent of the cases handled by him have a history of domestic abuse. Similarly, Dr Dinesh, the ob-

Mr Hemant Dwivedi, State Programme Coordinator of UNFPA in Rajasthan, notes that the state government is keen to address gender-related concerns such as violence as these also affect women's access to basic health services. 'However, any intervention needs a gestation period before adding value,' he says. He adds that showcasing the FCC processes can help highlight the ways of tackling VAW as a public health issue.

Most importantly, the FCCs in smaller district hospitals, such as those in Alwar and Karauli in Rajasthan, are filling a very critical gap by providing good-quality support services to people in a set-up constrained by poor infrastructure and where the staff offers varying levels of service quality. Coordinating medical services, informing people about various government benefits that they can avail, mediating with the police, etc. are labour-intensive but important interventions that the medical system is not equipped to handle, but if done well, they can improve the service delivery of hospitals. This is the gap that the FCCs are filling alongside their mandate of dealing with cases of VAW.

[11] Health is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity. Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19–22 June 1946; it came into force on 7 April 1948

gyn specialist at the district hospital in Karauli, says that women are able to open up about their problems because of the presence of a centre such as the FCC. According to him, nearly 10 per cent of women patients treated by him face violence within their families.

Challenges and constraints

It would not be incorrect to state that the FCCs have managed to secure a foothold within the health system. However, attempts to manoeuvre this space to increase their influence and expand their mandate are constrained by several factors.

A. **Lack of acceptance by some departments of the hospital:** While there is growing appreciation of the value added by the FCCs, this has not been accepted uniformly across all departments of the hospital. For example, in the district hospitals in Alwar and Karauli, Rajasthan, FCC counsellors have not been involved actively in medico-legal cases because of procedural barriers in issuing medico-legal certification reports, conducting autopsies, etc.

B. **Institutional support continues to be determined by the sensitivity and vision of individuals:** As has been pointed out earlier, in spite of being located within the hospital and involving health officials at the district and state levels, the success of the FCC is dependent on the sensitivity and support of individual officers. The transfer of supportive officials at the district and state levels can be detrimental to the smooth and effective functioning of the FCCs.

C. **Structural drawbacks:** Factors such as the mandatory participation of the counsellors as witnesses in court cases place constraints on the counsellors' time and effectiveness.

D. **The challenge of demonstrating the 'value added' by VAW interventions within the health system:** The two significant questions asked frequently by health-care providers are:

a) How can addressing VAW lead to better health outcomes?
b) What is the economic justification for investing in violence within the health sector, which faces several competing demands?

While these questions are not entirely new or unexpected, they nevertheless highlight important dimensions of understanding a health-sector response to VAW. Some of these are discussed briefly below:

- It is not possible to establish a linear cause–effect relationship between violence prevention and positive health outcomes. As discussed earlier, there are several direct and indirect, long-term and short-term, health benefits in investing in VAW, which have been well established empirically through international research.

- Data that can validate and throw light on these dimensions have not been collected systematically from these interventions. The interventions were not set up as operations research initiatives, and therefore are not geared to either measure or to analyse these angles adequately. It is also important to note, as pointed out earlier, that violence-prevention services contribute to improving the overall environmental factors that impact women's health status.

- There is a need to undertake research on the costing of VAW support services and to provide inputs for integrating data on violence into the MIS set up by the health system.

E. **Challenges of transitions in institutional arrangements and the overall programme environment:** The merger of IPDP with RCH2 under the UNFPA current country programme has affected the interventions negatively, at least temporarily. The transition has slowed

down, and in some cases halted, planned activities, especially training and sensitization programmes, and has created uncertainty about the future of the FCC. Direct support by UNFPA to the Government of India for these interventions is now being subsumed under the government's RCH2. To some extent, this has created ambiguity about the future of ongoing interventions.

The change in financial arrangements (UNFPA is now pooling its resources with the government's resources under RCH2) has also affected the flow of funds to the partners. The flow of funds from the government to the FCCs has nearly stopped since July 2005, placing smaller implementing partners such as the PMM under enormous strain. Their growing sphere of influence necessitates the continuity of the FCC. However, with few human and financial resources at their disposal, it is very difficult for the FCCs to continue functioning optimally. This is a very serious challenge as the time is opportune for consolidating and building upon the success of the FCCs within the hospital system.

Lessons Learned: *A synthesis of the key learnings in running a hospital-based counselling centre for victims of VAW*

- The experience of implementing the FCCs has highlighted the importance of several factors that are critical for setting up and running a hospital-based violence-redressal cell. Some of these factors are related to the broader policy environment, while others are related to the operational issues affecting the functioning of the cells. These are discussed below.

  A. A positive policy and programme environment related to women and health: The interventions in Maharashtra and Rajasthan have benefited greatly from the support and encouragement of proactive government officials at senior levels in the Health Department as well as administrators and medical officers in the districts. The counsellors at the FCCs spoke very highly about the positive role played by health officials, such as the Hospital Superintendent at the Chhatrapati Shivaji Maharaj Hospital, Kalwa, TMC, Maharashtra state and the PMOs at the district hospitals in Alwar and Karauli, in grounding the intervention, arranging for space to set up the FCCs, and, in due course, promoting the work done by them within the larger hospital system. Enthused by the success of the counselling centre, the earlier Health Secretary of Maharashtra initiated a protocol for women victims of burns and sexual assault. Plans are afoot to pilot the same in 2007 , with a large capacity-building component for implementing the protocol for both medical personnel and officers.

  B. The credibility, track record, and institutional networks of the implementing partner: The implementing NGO partners in Rajasthan (ECAT in Karauli district, PMM in Alwar) and Maharashtra (TISS) are well-known agencies that are recognized for their engagement with women's rights. This track record has facilitated their entry into the hospital set-up with greater ease. For example, TISS had conducted a research study on domestic violence in Chhatrapati Shivaji Maharaj Hospital, Kalwa, TMC. This process as well as the wide dissemination and discussion of the results with personnel at the various levels of the health system facilitated the setting up of Aarohi. TISS is a highly respected academic research institution, and has worked closely with the Municipal Hospital in Thane on earlier projects. Similarly,

the PMM, the implementing partner in Alwar district, Rajasthan, is well known for its involvement in cases of VAW, and has very good linkages with the district administration.

C. **The orientation and approach of the NGO partners to gender issues and women's rights, and their conceptual clarity on the issue of VAW:** The women-centred counselling process followed by Aarohi is based on the NGO's strong conceptual clarity on gender issues and women's rights. Similarly, ECAT, the implementing partner running the hospital-based counselling centre in the Karauli district of Rajasthan, adopts a rights-based approach to all their developmental work. This approach uses the media and statutory bodies in dealing with VAW.

- One of the most significant learnings that emerged from these hospital-based interventions has been the importance and advantage of locating the FCC within the hospital premises. It provides a readily available mechanism for doctors to refer patients. It also simplifies issues of access, time, and ready availability of services to women seeking its services. Most importantly, the FCC is non-stigmatizing, and the woman does not have to make a special effort to visit the centre since it is located within the hospital. By becoming a part of the hospital, at the very least in a physical sense, the FCC also projects the importance of this service as an addendum to treatment of physical illnesses.

- The FCCs have also demonstrated the importance of the 'mediating' role played by them in facilitating access to the medical services of hospitals. This is particularly significant in settings where the medical system is distanced from common people because of factors such as apathy, low motivation, and malpractices.

D. **The skill levels and perspectives of the counsellors providing support services to women facing violence:** The quality of counselling is central to the process of providing support and in dealing with the multiple needs of the victim. It is the commitment of the counsellors coupled with their skills in resolving cases that have been critical to the success of the counselling centre. Aarohi, for example, is staffed by extremely skilled counsellors who have been able to incorporate therapeutic elements into their counselling process, thus making the centre's services highly professional. Similarly, the hospital-based FCCs located in Alwar and Karauli districts of Rajasthan are being managed by very experienced counsellors, who are extremely sensitive to the socio-cultural realities of the region. Their understanding of the caste politics of the area has played an important role in resolving cases by involving key community leaders.

It is important to note that these factors are neither static nor uniform across all districts. They are a set of significant conditions that need to be put in place in order to set up and effectively run hospital-based FCCs.

UNFPA-supported community-level interventions on violence against women

UNFPA has supported community-level interventions on VAW through three community centres located at different sites in the state of Maharashtra. Two community centres are located each in Bhiwandi and Kalyan, Thane district. One centre is located in the Ganjpeth locality of Pune city. Included in this section is an analysis of these centres. The community centre in Kalyan is located within a civil hospital supported by the municipal corporation. The community centre in Bhiwandi operates out of the premises of the Deputy Commissioner of Police (DCP), Bhiwandi. The centre in Pune city is located in a community in the Ganjpeth locality.

The interventions discussed in this section of the report are:

a) The Family Counselling and Legal Guidance Cell located in Ganjpeth, Pune

b) The Centre for Women and Children Victims of Violence, located in Bhiwandi and Kalyan, Thane district

Introduction

Review team: 'At what stage of violence do women come to seek help?'

'It is not the duration of violence but the readiness of help available and the avenues of help that exist that, in fact, determine when the women will seek help . . . the existence of such centres is thus very helpful.'

Counsellor from the Legal Aid Centre, Pune

Internationally, violence-prevention research and practice has shown that interventions that challenge community norms on VAW and that mobilize broader public opinion on the issue have very successful outcomes. UNFPA has supported community-level interventions on VAW through legal aid centres that elicit community participation as well as tap into the agency of women's collectives in dealing with cases of VAW at the community level.

A brief description of the community centres:

- **The Family Counselling and Legal Guidance Cell**

Implementing Partner: Pune Municipal Corporation (PMC), Pune

Description: The Family Counselling and Legal Guidance Cell, which was established in early 2002, was started under the aegis of the PMC. Women's collectives, which had been mobilized under PMC's broader community development programme, expressed the need for an intervention that would enable them to address cases of VAW. The intervention was thus grafted onto an ongoing community development programme. The centre is managed by two counsellors. The PMC has allocated a separate structure for the counselling centre, consisting of two rooms and a hall to hold community meetings.

- **The Centre for Women and Children Victims of Violence, located in Bhiwandi and Kalyan**

Implementing Partner: Bharatiya Mahila Federation (BMF)

Description: The BMF is currently running two community centres that provide counselling services and support to women facing violence.

- **The Centre for Women and Children Victims of Violence in Bhiwandi** was started in early 2002. It is a community centre located within the premises of the office of the Deputy Commissioner of Police in Bhiwandi. The BMF was one of the first NGOs to set up base in Bhiwandi and also one of the first to begin addressing gender issues. They have a sound community presence in the area, and were taking up cases of VAW in the community long before the counselling centre began. The centre is managed by two counsellors.

- **The Centre for Women and Children Victims of Violence in Kalyan was started towards the end of 2003.** It is located in the Rukmini Bai Civil Hospital in Kalyan, and is managed by two counsellors. The counsellors are supported by a team of community-level workers, who conduct outreach activities, hold discussions on VAW, and do much of the leg work involved in dealing with cases of VAW.

Growth and evolution of the Family Counselling and Legal Guidance Cell in Pune, Maharashtra

I. **Genesis:** The PMC launched a community programme in August 2000 in the city slums of Pune with the objective of improving the status of women and addressing youth concerns. Under this programme, taken up by the PMC's Urban Community Development wing, women were organized into neighbourhood groups (NHGs). Savings and income generation were some of the issues around which the groups were initially organized. However, the broader objective of the programme was to empower women, and through them organize communities to identify and address women's developmental needs. This programme of the PMC met with a great deal of success, and in due course the NHGs also began expressing a need for violence-redressal services.

> The origin of this centre was need based. When we started working directly in the community, we realized that there are women who are facing violence within the family. In order to address this issue, we felt that it was necessary to provide some kind of legal help and counselling to those in distress. At the same time, we also felt that there needs to be awareness among the women as to what their legal rights are. Thus, when UNFPA suggested such an intervention, we readily agreed. Right from the start we knew we wanted such a kind of service within the department. So there was no question of not continuing the centres. When there are cases of violence, there is a centre where our staff can refer them. It is helpful . . . Being a Joint Commissioner, I have a lot of powers that I can use for the welfare of the community, and that helps me to accommodate new ideas. It is important that people have access to the system.
>
> *Mr Kalamkar, Joint Commissioner, Pune Municipal Corporation*

Every NHG is led by a residential community volunteer (RCV), and every cluster of 50 NHGs is supported by a group coordinator. The group organizers are in turn supervised by a social worker. NHGs play a critical role in informing the community about various schemes and facilities as well as in identifying beneficiaries for various government programmes. They are autonomous, set their own norms and priorities, and prepare and execute monthly plans. Capacity building of women through group processes has been an important aspect of this initiative.

II. **The successful ongoing neighbourhood programme of the PMC provides an ideal platform for integrating the Family Counselling and Legal Guidance Cell:** The strategy of forming NHGs for community income generation and other development activities has shown very positive results. That this is a government programme, led by an extremely proactive Joint Commissioner, Mr Kalamkar, and supported by an equally sensitive Deputy Commissioner, Dr Pardeshi, who was looking after IPDP, led to the inclusion of the PMC as an implementing partner under IPDP.

III. **The movement of the NHGs from practical to strategic gender needs:** Initially, skill

development and income-generation activities had been the major focus of the NHGs. At the same time, the NHG strategy of adopting a holistic approach to women's empowerment included providing access to information, skill development, employment, and decision making in the community. During the course of the implementation of the NHG programme, women expressed a need for addressing problems arising in interpersonal relationships at home and the resulting violence within the family. This has been an interesting trajectory as it established the readiness of the NHGs to begin delving into issues of more strategic interest to women. To address these issues, the Family Counselling and Legal Guidance Cell was established. The cell has a two-pronged approach:

a) Creating awareness among women about their rights and the relevant laws

b) Providing access to counselling, legal aid, and rehabilitation services

The role of the Family Counselling and Legal Guidance Cell was identified as that of enhancing interpersonal communication between couples and family members and enabling women to actively negotiate space for themselves in the family. It was projected as a pro-family initiative, which promotes women's empowerment and rights within the family while curbing violence and ill-treatment of women, children, and the elderly.

PMC also trained its own staff on GBV through an NGO called Tathapi so that they can better respond to cases and to the demands created by the sensitization of community groups.

Growth and evolution of the centre for women and children victims of violence run by the Bharatiya Mahila Federation

BMF is running the Centre for Women and Children Victims of Violence at two locations:

> Thanks to the NHG approach to development planning, prevention of VAW and provision of support services to victims of violence are now being viewed as an integral part of a broader strategy of empowerment.

- One community centre is located in Bhiwandi, within the premises of the office of the Deputy Commissioner of Police (DCP); it has been functioning since July 2003.

- The other community centre in Kalyan is located within the premises of the Rukmini Bai Civic Hospital; it has been functional since the end of 2004.

The main objective of setting up the centres has been to provide immediate assistance to women victims of long-standing and acute violence.

I. **Genesis:** BMF, the agency implementing this intervention, is an all-India organization with its roots in the country's independence struggle. Its director, Ms Geeta Mahajan, was motivated to begin working on community development issues through her association with people's movements and women's groups in Thane. The BMF was the only NGO working in the far-flung area of Bhiwandi. This area is dominated by a large migrant community, and is notorious for high rates of crime and frequent riots and arson. It has a sizeable Muslim population, is not easily accessible, and lacked a civil society presence when BMF first began working here in 1994.

Outcome of the paramedical staff training on GBV in Pune

- Trained staff began relating VAW to their personal experiences
- Increase in to-and-fro referrals by the health staff to counselling centres, and vice versa
- Health staff experienced a change in their attitudes towards survivors of GBV
- Health staff began recording incidents of VAW in case papers

BMF initially began working in Bhiwandi on community development issues. A cadre of volunteers, largely women, began addressing several civic issues, such as the functioning of schools and public distribution shops. In the course of their work, they also began addressing cases of VAW. When UNFPA decided to work in Bhiwandi, BMF seemed an obvious choice given their focus on gender concerns and community mobilization and their sustained presence in the area.

The journey so far by the Family Counselling and Legal Guidance Cell, Pune and the Centre for Women and Children Victims of Violence in Bhiwandi and Kalyan

The section below describes the approach and strategy adopted in instituting community-based interventions: (a) the strategies adopted in addressing community norms; (b) the challenges encountered; (c) the signs of change; (d) the constraints faced; and (e) the lessons learned during the entire process.

The broad operational steps in establishing community-based counselling centres are:

I. Identification of appropriate implementing partners with a strong commitment to and conceptual clarity about gender and women's rights.

II. Orientation of various stakeholders within the local community about the activities of the counselling centre

III. Training and capacity building of FCC counsellors

IV. Development of MIS formats VII. Outreach activities

II. **Location of the community centres has been a strategic choice:** The decision to locate the community centres—one within the premises of the DCP's office and the other within a hospital—was prompted by several organizational and environmental considerations. The main factors that led to the setting up of the centre within the premises of the DCP's office were:

- the availability of space
- the presence of an active and supportive DCP
- the strong links that the BMF has with the local police
- the BMF's own strong community presence in Bhiwandi
- the central location of the police station, enabling easy access to women from the community

The location of the centre also enabled it to leverage the authority of the police in addressing cases of VAW, without their direct intervention. The setting and location of the centre accords it a certain informal legal status, which is of enormous advantage in negotiating with perpetrators and dealing with instances of violence.

The decision to set up the community centre within a civic hospital in Kalyan was prompted by the following considerations:

- Availability of a centrally located space that was easily accessible by women in large numbers
- The advantage of a safer and relatively less stigmatizing 'label' provided by the hospital
- Unlike Bhiwandi, in Kalyan, the NGO did not have a strong community base or links with the police and government departments. Hence, the relative advantages of locating the

community centre in the police station were absent.

- Space being a serious constraint in Thane, the willingness of the hospital system to set up the centre was also a deciding factor.

Strategy and approach of the two community-based interventions: Some common features are:

1. **The Family Counselling and Legal Guidance Cell and the Centre for Women and Children Victims of Violence accord primacy to the role of the community and the family in responding to VAW.** Both organizations believe in challenging and changing the broader societal norms that sanction VAW by improving their overall status. The PMC's strategy of mobilizing NHGs and developing mechanisms to support their growth (e.g. identifying RCVs, registering the NGH clusters as a separate legal entity) is informed in part by the need to build the collective strength of women and to enhance their social capital. This approach is seen as essential in empowering women and in reducing power inequalities between men and women. The centres being run by the BMF engage with the community largely through rigorous casework and engage closely with the woman to help build her own space within the family.

2. **The programme of the PMC and the work done by the BMF prior to the setting up of the centres have created a strong platform on which to mount their work on VAW.** While the BMF had been addressing cases of VAW even before the counselling centre began, this intervention has enabled them to systematize and consolidate their work on VAW. It has provided them legitimacy as well as greater financial support. The Family Counselling and Legal Guidance Cell has enabled the NHGs organized by the PMC to begin addressing the issue of VAW more strategically.

The NHG initiative helps in reducing violence within the home and the community by:

- strengthening the role of women in the area of community development
- helping women by providing a support network
- creating social and legal awareness about gender-based violence within the community
- enhancing women's capacities to behave and communicate assertively

3. **An alternative to litigation:** The BMF and the PMC both view the counselling services as an alternative to litigation, which is not only impersonal expensive, and time consuming, but which also causes enormous mental stress and is inaccessible to women most of the time. Women seek a quick solution to their problem, and in its absence they become resigned to violence in their lives. The counselling cells run by both agencies provide a neutral platform where women can negotiate with their families. The counselling process followed at both the community centres involves listening to the woman, identifying her needs, enabling her to fight for her rights by giving her information and support, and bringing all the concerned people to sit together and arrive at a negotiated settlement. Preparing the woman and her family to accept any decision that she takes is an important aspect of the counselling process.

Key features of the strategy and approach adopted by the Pune Municipal Corporation:

- **Capacity building of NHG members is a key feature:** The PMC-led initiative builds the capacities of NHG members in dealing with cases of violence at the community level by enhancing their negotiating skills, boosting their confidence to articulate their points of view, and increasing their awareness of women's rights. Each NHG is led by an RCV. The empowerment of NHGs is seen as a crucial component in developing

community-based strategies to combat domestic violence. Simultaneously, broader support of key community leaders, police functionaries, opinion makers, ward members, etc. is seen as essential for sustaining a violence-free life for women. The community-level workers of the PMC also network actively with the police and other departments and agencies, as well as with other NGOs to increase women's access to support services.

- **Perspective on VAW:** The strategies employed by the PMC initiative are rooted in the organization's perspective on VAW. This perspective recognizes and respects the complex realities of women's lives and the fact that women do not necessarily want to break away from the family but do seek greater space, an increased voice, and more power in decision making. The Family Counselling and Legal Aid Cell views violence as resulting from a lack of decision-making spaces for women within the family, lack of communication between couples, and lack of awareness in the community about women's rights. Thus, the role of the Family Counselling and Legal Guidance Cell has been identified as that of enhancing interpersonal communication between couples and family members and enabling women to negotiate greater space within the family. Hence, it seeks to make family relations safer and more equitable for women without necessarily denouncing the notion of the 'family'.
- **Raising awareness in the community about the rights of women and the legal provisions available to them is an important objective of the Cell.** Initially, in order to make the community aware of the services of the counselling centre and to sensitize people to the issue of gender-based violence, community-level meetings were organized and pamphlets explaining its purpose, location, etc. were distributed. A lawyer was also invited to address community members on the legal rights of women and ways of accessing legal redress. Gender issues were not dealt with openly at the initial meetings. Thus, the effort was, and to a large extent continues to be, to democratize family relations and not necessarily to facilitate the woman's separation from the family.

UNFPA's strategic intervention for improving the identification and referral of cases to the Family Counselling and Legal Guidance Cell: Facilitating sensitization of the nursing staff in Pune

An important intervention supported by UNFPA for strengthening the linkages with the health system was the sensitization of various levels of nursing staff working in government hospitals and health outposts in Pune city. A total of 264 nurses, including ANMs, staff nurses, matrons, and nurses, were trained in 10 batches by Tathapi, a well-known resource agency. One of the objectives of the training was to facilitate greater referrals to the counselling centres.

Key features of the strategy and approach adopted by the BMF in dealing with cases of VAW:

- Enhancing the victim's capacities to deal with the situation: The broad approach adopted by the BMF is to work closely with the individual woman to build her capacities in negotiating and dealing with the violence that she is facing. To this end, the assistance given at the centre consists of active listening, counselling,

Measures for increasing community awareness adopted by the Bharatiya Mahila Federation

- Organize legal literacy camps in the community to make women aware of their legal rights
- Address VAW through the media (street plays, posters), so that the issue gains visibility in the community
- Celebrate specific events (fortnight of VAW, International Women's Day, Population Day) to discuss every woman's right to lead a violence-free life
- Engage actively with other issues that concern the community in order to build community support and secure credibility

'Now that there is a centre functioning, women can come here to ask for help without being dependent on anybody. They are not scared to come here, and they feel that their problem will be solved.'

Counsellor, Legal Aid Centre, Pune

providing sympathetic and emotional support, arranging for medical and psychiatric help, giving information on legal rights, and intervening to get police assistance and legal aid. In addition,

- In critical cases, shelter is provided at short-stay homes until rehabilitation.
- At the centre, counsellors, based on their experiences, reported that for an average annual caseload of 100 cases, a majority of women and family members receive counselling, around 10 per cent cases receive police help, 14 per cent get legal aid, and 10 per cent receive medical and psychiatric help.
- The centre also organizes educational assistance for children in abusive or violent families. Education is viewed as an important prerequisite for empowerment of women and children.

- A multi-pronged approach targeting women and key community stakeholders: The centre has adopted a multi-pronged strategy that not only seeks to alleviate the individual woman's condition but also to mobilize the community to view violence as a significant barrier to women's health and economic well-being. Hence, it tries to create mechanisms where gender-based violence is dealt with at an individual level through intensive counselling, referrals to support services, life-skills development, etc. At the same time, the broader community is also targeted by mobilizing and sensitizing systems at the macro level (the police, hospitals, political leaders) that can play a role in curbing violence; developing public opinion on the non-acceptance of violence; and creating community awareness about gender discrimination and VAW. The BMF has also been sensitizing police personnel and civic groups such as mahila mandals and community leaders.

Signs of change

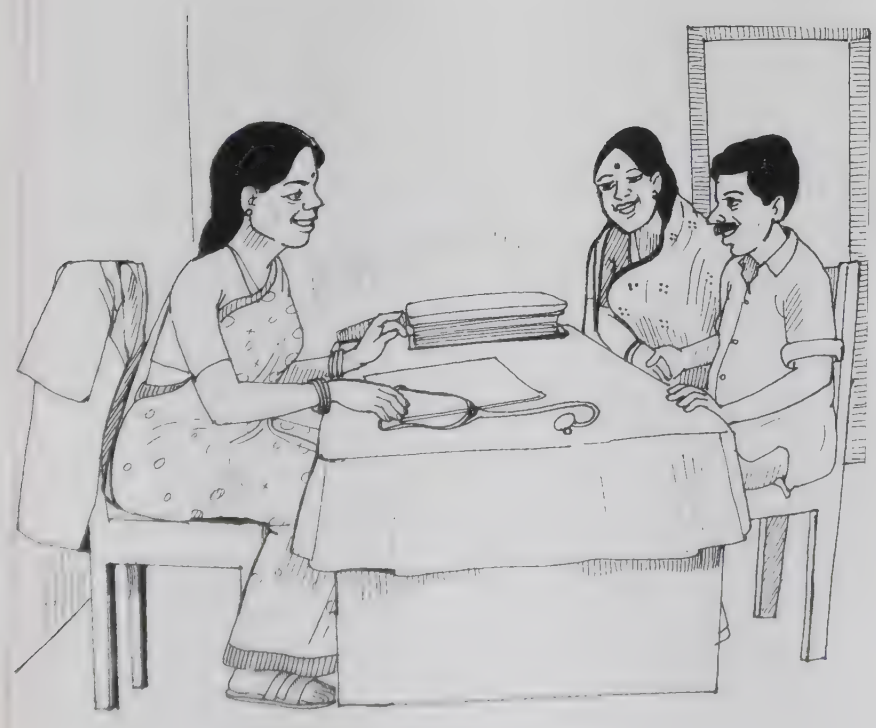
This section examines some of the signs of change visible at various levels resulting from the work of community-based counselling centres. However, it is important to recognize that in the absence of quantitative and empirical data, much of this assessment is based on qualitative and subjective perceptions of change. Nevertheless, it provides valuable insights into the effectiveness of the interventions and confirms the existence of a movement from passive acceptance of violence to active engagement with and resolution of the problem both at the micro and macro levels.

- Increasing caseload: Growing community awareness about the issue and the existence of a violence-prevention centre where women can seek redress is resulting in an increase in caseloads. According to the BMF, from the beginning of 2003 to the end of 2005, 241 cases were registered at the Bhiwandi centre, out of which 20 per cent (49 cases) have been closed. Out of the 49 closed cases, reconciliation was brought about in 22 cases, separation in 15 cases, and 10 cases moved to court. Two cases of child rape and two cases of suspicious deaths of women

were registered. On an average, eight new cases are being registered every month at the Bhiwandi centre. Almost two-thirds of the women approaching the centre are from the Muslim community. The experience of the NHGs has been similar. Former clients are often the most vociferous advocates of the centre, and have been actively referring other women to the centre.

- **Better detection of cases of violence:** Exposure and sensitization to the issue of VAW has resulted in greater identification of cases by both health personnel and community members. Following their training nurses were found to have referred cases of violence to various support organizations in Pune city. The Sakhi Help Line for women, the special cell for women and children, and the PMC-run legal advice and counselling centre have reported five to eight cases referred by nurses after the training of each batch. Interestingly, the training also resulted in reporting of violence from among the health care providers themselves.

- **Increased cooperation from other stakeholders:** According to Ms Geeta Mahajan, Director of BMF, the meticulousness with which the centre pursues and resolves cases has resulted in greater cooperation from the police, doctors, and other community leaders. The counsellors often work closely with police officials to ensure that women's cases are booked under the appropriate section of the law in order to secure justice. According to the counsellors from the community centres in Kalyan and Bhiwandi, police officials find such advice and contribution very useful. They are often ignorant about the intricacies of the law and the appropriateness of specific sections in strengthening the case in court. These inputs are offered by the counsellors based on their in-depth understanding of the experiences of women suffering violence.



- **Setting up of new centres by the Pune Municipal Corporation:** By bringing the issue of VAW into the fold of mainstream community development (through the neighbourhood model in Pune), the cell has demonstrated the relevance of violence prevention in development planning. Impressed by its effectiveness, the PMC has set up three more centres. This decision was also prompted by the learning that distance and location play a very important role in enhancing women's access to such services.

Lessons Learned: A synthesis of the key learnings culled in implementing community-level interventions on VAW

The experience of running the community centres highlights the importance of the following factors in the setting up and effective functioning of such an intervention:

- The perspective of the implementing agency on the issue of violence, and its analysis of the underlying causes and consequences of, and the appropriate responses to, the issue, all heavily influence the approach and strategy that the organization will adopt in addressing VAW. The BMF and the PMC strongly believe in community participation in dealing with the issue of VAW (the term

'community' is used here in both a physical and a notional sense). Hence, they engage with key stakeholders, community leaders, police personnel, and health-care providers in resolving cases of violence. They view violence as a result of patriarchal control over women and of the women's inability to articulate their real needs. Hence, their strategy of social mobilization is aimed at nurturing a sense of agency among women, and their counselling strategies are aimed at increasing the space for women within their families while giving them a voice. Related to this is the strategy of both organizations to link the issues emerging from an individual case to the broader issue of VAW in their outreach efforts.

- **The appropriateness of the location is highly contextual:** One of the most significant learnings of the community-based interventions on VAW has been that the context determines the suitability of the location of violence-redressal services within the community. The active linkages of the BMF with the police in Bhiwandi as well as its community presence in the area have served as advantages in locating the community centre in the premises of the DCP's office. On the other hand, in the absence of such an advantage, it has been more useful to locate the counselling centre within a hospital in Kalyan as it is less stigmatizing and is also centrally located, thus making it more accessible to women.

- **Community-level interventions on VAW are strengthened by the implementing agency's engagement with other developmental issues of community interest:** The PMC and the BMF had dealt with several issues of community interest and importance (savings and credit for women, vocational training, civic amenities, etc.) before they began addressing the issue of VAW. In doing so, they had created a certain presence and stature for themselves in the community that facilitated their interventions on an issue as sensitive as VAW. At the same time, they continue to work on a variety of issues within the community, which in turn enables them to intervene in more cases of VAW.

Synthesis of lessons learned from the UNFPA-supported interventions on violence against women

A brief recapitulation of the range of responses to VAW supported by the UNFPA India Country Office:

UNFPA's experience of supporting these pilot interventions highlights the range of strategies and approaches that fall under the rubric of a coordinated systemic response to VAW. The entry point for each of the interventions is different.

- At one end of the continuum are responses located within the hospital, working alongside doctors and paramedics and sensitizing them to detect and refer cases of VAW. (Examples are hospital-based counselling centres such as Aarohi located in the Chhatrapati Shivaji Maharaj Hospital, Kalwa, TMC and the FCCs located in the district hospitals of Rajasthan.)

- Interventions that are located within police premises and those using the police station as their entry point are facilitating access to law enforcement agencies. They are also utilizing their location as well as their closeness to the police to bring the perpetrators to the negotiating table and to argue on behalf of the woman from a position of greater strength. (Examples are the help desks in Orissa and the Centre for Women and Children Victims of Violence in Kalyan, Thane district, Maharashtra.)

- Where the community is the entry point, the interventions are challenging broader social norms regarding VAW and enabling women to build the social support needed for dealing with such issues in their lives. (Examples are the Family Counselling and Legal Guidance Cell in Pune and the Centre for Women and Children Victims of Violence in Bhiwandi, Thane district, Maharashtra.)

Key insights and lessons learned

- These interventions highlight the fact that the relative advantage of one entry point over the others is highly contextual. It is dependent on the key stakeholders engaged in the process as well as the implementing partners' linkages with a given system and their track record of having worked on the issue.

- Although these interventions span various locations and settings, they nevertheless highlight the importance of a specialized centre or cell that can provide counselling support and undertake the considerable legwork involved in dealing with cases of VAW. This is a very important factor because neither the police nor the hospital system are really equipped to meet the many immediate and/or long-term needs of women trapped in abusive relationships. Police stations and hospitals are part of a work culture that is task driven, hierarchical, and not always people friendly or women centred. Doctors inspire awe, and police personnel inspire fear. Given this reality, the mediating role of NGOs and civil society institutions on an issue such as VAW becomes very valuable.

- Among the interventions examined in detail in this report, those located within a community setting address the needs of the individual woman, but by doing so they also seek deliberately to influence the broader environment affecting women's status in the community. In contrast, the focus of hospital-

based interventions is more on the individual woman and on enhancing her capacities to cope with violence. Thus, the two interventions differ in their level of engagement with the physical and notional community, which affects the woman in an immediate way.

- The capacity of the implementing partners, their perspective on VAW, and the skill levels of the counsellors, which in turn influence the quality of counselling, are the key determinants of the effectiveness of the interventions.

Based on the examination of the various interventions on VAW, the key elements that may be described as critical in instituting an effective intervention programme on VAW include:

1. Selection of implementing partners with
   - Strong commitment to gender justice and a sound track record of having worked on strategic gender issues
   - Strong conceptual clarity on women's rights and the different dimensions of VAW
   - Strong networks with other agencies and government departments

2. Selection of skilled counsellors capable of providing quality counselling services.

3. Well-planned mechanisms for capacity building and mentoring of the counsellors in maintaining high standards in counselling and in preventing burnout.

4. Strong technical support to the implementing partners on developing a multi-sectoral approach to understanding VAW as well as on honing specific skills, such as mediation, casework, and recording and documentation.

5. A rigorous standardized monitoring and evaluation framework to create an evidence base, to track changes, to measure key outcomes, and to facilitate cross-site comparisons.

6. Adequate infrastructure for implementing the intervention. It is desirable that counselling centres should have at least two counsellors and a support staff, and communication equipment in the form of a computer and telephone and fax facilities. In addition, counselling centres located within community settings should also budget for outreach activities and at least two staff—a male and a female—for carrying out activities in the community.

7. A supportive policy and programme environment in the form of sensitive government officials is necessary along with institutionalized procedures that ensure administrative compliance with the need to integrate violence-redressal services into various government services. Examples of this could be making collection of data on violence through a screening process a part of the routine MIS of the hospital system, or a government regulation on screening women for violence, or a memo from the hospital superintendent (or her equivalent) asking nurses and doctors to be alert for telltale signs of VAW. By doing so, officials set norms within the system and ascribe priority to such issues.

8. Long-term funding over at least a five-year period.

The prerequisites mentioned above are in the nature of the basic minimum conditions that need to be in place for implementing a systems-based response to VAW.

The ways forward: programmatic and policy considerations

Some of the programmatic and policy considerations emerging from an analysis of the experience of implementing the range of interventions discussed in this report are given below. Combinations of policy and programme actions are necessary for integrating and strengthening violence-prevention services within formal systems. It is also important to recognize that some of these are largely short term, and that the overall goal of integrating gender concerns has to be a broader agenda on which policy making is based.

Policy recommendations

1. **Strengthen policy initiatives for integrating violence-redress services within hospital settings:** The value added by violence-redress interventions located within health settings is amply demonstrated by the growing success of the FCCs. The number of women approaching them for redress is on the rise. FCCs are performing two important functions:

   - Counselling women trapped in abusive situations

   - Facilitating access to various services and facilities offered by hospitals, such as subsidized treatment, medicines, and prenatal nutritional supplements; reimbursement for certain services; availing blood free of cost from the blood bank; and information about government incentives for families with girl children.

While the facilitating role mentioned above is not the primary objective with which the FCC was set up, it does highlight the importance of such a mediating service in a government set-up, which is distanced in many ways from the people. At the same time, it is important that the FCC does not become co-opted into performing the facilitating role mentioned above, which takes it away from its primary mandate of addressing VAW.

Nevertheless, policy initiatives for institutionalizing violence-intervention services within a health-care setting are strongly validated through the interventions reviewed in this report.

2. **Institutionalizing capacity building on gender issues and VAW:** Gender discrimination, status of women, and VAW should become a part of the regular induction and/or training curriculum of health personnel. Sensitization to gender issues should be institutionalized, continual, and sustained, and should cut across every level of the health system. As the counsellors at Aarohi (FCC, TMC) stated, 'To institutionalize a response, the whole system needs to be sensitized.' This is critical in ensuring that addressing gender concerns through the health system is not left merely to the goodwill and sensitivity of individual officials, but becomes a part of their official mandate.

3. Undertaking a policy push for funding and running more well-managed shelters and short-stay homes: One of the most serious lacunae in the area of violence prevention and redress is the lack of alternative shelters for women and children facing abuse. Existing shelters are largely urban based and of very poor quality. State and international funding in this area is accorded very low priority. Counsellors and practitioners have repeatedly stressed that the lack of alternative shelters is one of the biggest constraints in offering viable

solutions to women who may wish to escape from an abusive environment. Alternative shelter is not just a support service; it also strengthens the woman's negotiating powers considerably in an abusive situation. The existence and availability of well-run shelters can also become a motivating factor for women in reporting abuse.

4. Recasting the policy-making process to reflect women's realities more substantially: That VAW is a serious deterrent to development is only just being understood by policy makers and planners. In addition, the policy-making process in India is very complex, and not always adequately geared to reflect the 'aspirations from the ground'. In such a situation, one often finds that while practitioners and programme implementers at the village, block, and district levels are constantly witnessing the debilitating health effects of VAW, this reality does not percolate to and influence the priorities assigned to the health concerns of women at senior policy-making levels. There is an urgent need to correct this anomaly so that policy initiatives can reflect women's concerns and truly provide a supportive environment for actions at the district, block, and village levels. In order to deal with the situation of violence in an effective manner, different stakeholders need to work together so that a coordinated response can be developed. This requires greater administrative cooperation and coordination on the part of the government and the different development partners and implementers working within a given state.

5. Instituting proper mechanisms for providing feedback and information to the formal system is extremely critical: This not only enhances communication between counsellors and government officials in general but also makes government actors aware of where and how they are contributing to the intervention, as well as increasing their knowledge of the positive results of such an intervention. The counsellors at Aarohi (FCC, TMC) have stressed the importance of creating an information feedback loop that builds a greater sense of involvement. Such a process also motivates the often overstretched medical staff and police personnel to extend themselves even further.

6. Increasing the effective utilization of funds on infrastructure: Increased investment in health and other development infrastructure is required urgently. District hospitals are often very poorly equipped, and issues such as inadequate privacy, lack of space, and absence of seating also impact the effectiveness of their overall functioning, including the priority that is accorded to specialized interventions such as the FCCs.

Programme recommendations

1. It is imperative that VAW prevention and support services be given an adequate 'gestation' period for establishing themselves and for consolidating their achievements. In a one- or two-year programme cycle, it is difficult for hospital-based interventions to demonstrate their viability and their 'value added'. This reality needs to be factored into the planning and design of such interventions. Therefore, technical and financial support for these interventions needs to be fairly long term,

sustained, and well planned. This long-term planning preferably should be a part of the concerned government's vision and programme planning for a given period.

2. Rigorous monitoring and evaluation frameworks for measuring the outcomes and the 'value added' through such interventions need to be strengthened considerably: Monitoring frameworks should be designed to track quantitative changes (e.g. changes in caseload, profile of clients, nature of cases, referrals from different departments, profile of perpetrators, number of times the woman has sought health care for treatment of injuries, etc.) as well as qualitative changes (changes in self-perception and self-esteem, perceived changes in the woman's health status as a result of the counselling intervention, changes in her ability to cope with the violence, changes in the perpetrator's attitude and behaviour, etc.). Well-designed participatory exercises that elicit reflection and analysis on the shared experiences of the counsellors and the NGO partners in implementing the interventions can also serve as an extremely rich and valuable source of data. Data of such a nature can not only help measure the results of such interventions, but they can also be of considerable value in advocating the integration of violence-redress services into health settings. Well-planned and rigorous mechanisms for monitoring progress and operations research can be of great value in this context.

3. Strengthening mechanisms for reflection, analysis, and peer learning that enable counsellors to review their work collectively, to discuss common learnings, and to provide feedback to each other is recognized globally as a critical element of any successful practice aimed at violence prevention. This has happened spontaneously among the counsellors at Aarohi (FCC, TMC). However, instituting such mechanisms can prove to be invaluable in building a common and sharper perspective on violence. UNFPA Maharashtra has set a good example in this regard by putting in place a mechanism through which all partners working under IPDP can meet on a monthly basis for half a day and apprise each other of their work and discuss issues of relevance.

4. Training and capacity building of front-line workers engaged in providing support services to victims of VAW is an oft-neglected but extremely important element of VAW interventions. It needs to be accorded very high priority in the project-planning cycle. Refresher training programmes for counsellors on specific issues, such as legal provisions for women, government programmes, advocacy skills, conflict-resolution mechanisms, casework, etc., can enhance their effectiveness. Similarly, providing inputs to front-line functionaries of key government departments (as a part of their ongoing training programmes) to both work jointly and address violence individually is critical if a multi-sectoral response to a complex issue like VAW has to become a reality.

Steps followed by the FCC in Rajasthan in responding to a case of violence against women

- A written application describing the problem faced by the client and the help that she is seeking is taken from the client.
- The counsellor offers an attentive ear and listens closely to what the woman has been through as well as what she wants.
- The counsellor helps the client to analyse for herself what her immediate needs are and those issues that are more long term.
- If the client wants to file a police complaint, she is informed about the process and all the legal implications.
- The reasons for the violence are explored during the counselling sessions. The client is helped in identifying the ways in which she thinks her problem can be solved. Her support structure, allies, vulnerabilities, etc. are also explored with her during this phase.
- The perpetrator is called to the centre through a letter or, if needed, a home visit is made.
- The perpetrator is allowed to present his version of the story and to recount his side of the problem.
- A joint session may be held, during which both parties are made to tell each other their views and to air their problems.
- If the client wants to compromise and return to the family, she may be helped to do so through a negotiated settlement with strict safeguards in place for her safety.

Case studies

Over the last one and a half years in Rajasthan and over three years in Maharashtra, the FCCs have addressed several cases of domestic violence, sexual assault, harassment, and abandonment. Some of these cases have received more publicity than others, and have helped establish the mandate of the FCC within the hospital more clearly.

Ruksana* (Alwar district, Rajasthan)

According to the counsellors at the FCC Alwar, Ruksana's case is one of the most successful ones that they have resolved. It involved coordination with the police, media persons, and several departments within the hospital. Ruksana was left at the hospital gates by a local rickshaw puller. She was very distressed, both physically and mentally. She was unable to give her address, or name the place she was from, or even remember her own name. In addition, she was unable to speak in the local dialect and hence could not communicate clearly, which added to her distress. She was provided immediate medical assistance thanks to the intervention of the counsellors, who discovered that she was five months' pregnant. The FCC contacted the police for help in tracing her family, and requested the local newspaper to carry a story about her in order to locate someone who could speak her language and provide help in identifying her. The counsellors made arrangements to provide Ruksana with basic supplies such as clothes and food. With the constant support of the counsellors, Ruksana slowly regained the mental and physical strength to begin discussing the traumatic events of her life that had landed her at the hospital. It soon became clear that Ruksana was from the state of Assam, and had suffered severe sexual abuse and a great deal of mental torture. She had reached Alwar with the help of a truck driver. She was unable to identify the father of her child. After several months of intensive counselling and hand holding, Ruksana expressed a desire to return to her village in Assam. The counsellors worked closely and intensively with the police in tracing her parents, and eventually managed to contact them. Ruksana was ultimately sent to her village under police escort. She is now living with her family in Assam.

The story of an ANM who sought help from the FCC in Karauli district, Rajasthan

According to the counsellors at the FCC in Karauli, this is among the most successful cases they have handled. An ANM, who had heard of the FCC at a presentation made by the counsellors at an ANMs' training programme, reported that she was facing severe stress in her marriage because of her husband's desire to exercise constant control over her. He took away all her earnings and did not allow her to keep any money for herself. He harassed her constantly for her money. The counsellors held several counselling sessions and coached the woman on the need for being assertive about her right over her earnings. They helped her realize the importance of her contribution to her family's welfare, and encouraged her to be confident and forceful in communicating her needs to her husband. After much counselling, the ANM reported the woman's position of increased strength in negotiating with her husband and expressing her wishes about controlling her own finances. She now no longer feels pressurized to hand over all her money to her husband.

Shanta Bai (Aarohi counselling centre, Thane, Maharashtra)

Shanta Bai, a 45-year-old woman belonging to a low socio-economic group, earned a living by collecting and selling discarded vegetables from the wholesale market. She was admitted to the casualty ward with multiple injuries on the stomach, neck, and back. Her ribs were fractured, and she was suffering from internal injuries and cuts on her hands. She was very scared. On being asked, she said that she had fallen and hurt herself. She also said that she did not want any help.

She was admitted to the hospital once again, this time complaining of continued suffering from her wounds. She said that her neighbours had beaten her. She refused to give any more details. Shanta Bai was admitted for a third time, this time accompanied by a neighbour who pleaded a fee waiver on her behalf. On further probing, it was discovered that Shanta Bai's neighbours had beaten her with stones and sticks because they believed that her son was insane and hence a nuisance; they wanted her to leave the locality. On visiting her house, the Aarohi counsellors found that it was located in the middle of a neighbourhood dominated by the higher castes.

Finally, Shanta Bai and the neighbour who had accompanied her to the hospital were persuaded to lodge a police complaint. However, the police response was not encouraging. They never enquired into the incident, always citing their inability to trace the house as the reason. The Aarohi team made a home visit and made it clear to the neighbours that Shanta Bai was not alone, and that she was supported by the police, the hospital, and Aarohi.

Her economic status was found to be very poor. Shanta Bai's family consisted of her old and handicapped husband and a son. The son was a young man of 23, who was considered by the neighbours to be a dim-witted youth suffering from mental illness. He was referred by the Aarohi counsellors to the psychiatric department for an assessment. Doctors detected no abnormality. Aarohi continued to follow up the matter with the police. Finally, a policeman went to Shanta Bai's house and threatened the neighbours. They in turn threatened Shanta Bai, saying that they would destroy her house.

In the meantime, the counsellors at Aarohi worked with the son and found him a job at a security agency. He discussed his problems with the Aarohi counsellors. He turned out to be a great support to his mother. The neighbour who had accompanied Shanta Bai headed a satsangh (religious) group, and was of considerable help in confronting the violence. The support of the satsangh group helped in gaining legitimacy for Shanta Bai and her family within the predominantly higher-caste group. More importantly, Shanta Bai also realized through her interaction with Aarohi that her husband was not severely handicapped and that he was capable of taking up some family responsibilities. Slowly, he started helping with the family finances by managing a small shop.

This case highlights the importance of working within the prevailing social context when attempting to change power equations and curb violence. It was important to work with the entire family and sympathetic neighbours to strengthen Shanta Bai's support system. The fact that the hospital, the police, and Aarohi were behind the hapless woman was a major factor in deterring the hostile elements in her community and neighbourhood from attacking her and her family.

Sona (Family counselling and legal guidance cell, Pune)

Sona's husband was not only an alcoholic but he also refused to give her any money for household expenses. He frequently took loans for purchasing liquor. Sona had to look after the family and repay his debts from her meagre earnings of Rs 800 a month which she earned by rolling bidis. When she asked her husband for money, she was beaten

and abused. Sona came to the Legal Guidance Cell with some members of the NHG. The cell sent a letter to her husband, followed by another reminder. The fact that Sona had approached the cell, and that NHG members supported her, acted as a deterrent, and the abuse stopped. Sona's husband promised to behave himself, and this was endorsed by the NHG members.

Bhagyashree (centre for women and children victims of violence, Bhiwandi)

Bhagyashree was harassed mentally and physically by her husband, brother-in-law, and his wife for dowry. She was forced to return to her natal family, which was extremely poor. When she approached the centre for help, she was unwell, very weak, and depressed. She was given medical treatment and free legal aid for securing maintenance for herself and her daughter. The husband did not respond to the letters sent to him by the centre. He also refused to accept the court summons issued under a case filed by Bhagyashree under Section 125 of the Criminal Procedure Code (CrPC) pertaining to maintenance. Finally, the centre arranged to send a volunteer to Pune, and the summons were served on him. The husband finally appeared in court, and Bhagyashree was granted a monthly interim maintenance of Rs 600. She has managed to secure regular maintenance by filing recovery applications. She is now well, and supports her handicapped parents and daughter by taking up small jobs.

United Nations Population Fund - India
55, Lodi Estate, New Delhi 110003